2009 BWC Policy Alert

Managed Care Organization Policy Flash **January 2009**

Alert # 01-2009-05 Global Surgical Care: Services Included in the Global Package

Reference Policy: Global Surgical Care- Coding and Reimbursement Standards, Clinical Editing

Location: http:// www.ohiobwc.com/downloads/blankpdf/BRM3.pdf (Chapter 3)

Purpose: This policy alert addresses the application of correct coding and reimbursement standards, specifically, billing protocols for medical services provided as part of the surgical procedure under the Global Surgical Care.

Issue: Among other clinical edits, BWC implemented the standard edit for global surgical care. The edit has resulted in the rejection of a number of submitted bills. The primary reason for the rejections has been due to a physician, other than the surgeon, submitting bills for post-operative care which falls within the standard global services policy. While this should have been a standard edit by the MCOs' billing review, the result indicates a disconnect and limited understanding of the current policy and its application.

Explanation: Continuity of care is an important component in the delivery of quality care. Thus, the physician performing surgery is in the best position to continue and/or arrange the coordination of care for the injured worker through all phases of care for the surgical procedure. In those instances when the operating physician is performing pre-operative, intra-operative and post-operative care, a modifier is not required and reimbursement will be 100% of the BWC fee schedule.
Example: Repair of ruptured musculotendinous cuff (e.g. rotator cuff) open; acute must be submitted as CPT® code 23410 with the date of service the care was rendered.

However, there are legitimate situations when global surgical care is not rendered by the surgeon. Below are examples of different scenarios and reimbursement instructions to facilitate appropriate reimbursement to each service provider. The total or sum of reimbursement for all services performed in a global surgical care scenario is the same regardless of how the billing is divided between different providers involved in the patient's care. Correct coding guidelines require that when the components of a global surgical package are performed by different physicians, the same surgical procedure code (with the appropriate modifier) be used by each physician to identify the services provided. The pre-operative service must be billed with the date of service that it was

performed. The intra-operative and post-operative services must be billed with the date of the surgery as the date of service. Please note that the post-operative recovery period is 10 days for minor and 90 days for major procedures.

- A physician providing only the preoperative evaluation component of a global surgical package (with another physician performing the surgical procedure and postoperative care) must attach modifier 56 to the surgical procedure code. An evaluation and management (E/M) visit code is inappropriate. **Example:** Repair of ruptured musculotendinous cuff (e.g. rotator cuff) open; acute must be submitted as CPT® code 23410-56 with the date of service the care was rendered. This portion of the procedure will be reimbursed to the non-operating physician at 10% of total fee of the rotator cuff repair.
- A surgeon performing only the surgical component of a global surgical package (with another physician providing the postoperative care) must attach modifier 54 to the surgical procedure code. Note: **The physicians involved in such care must first agree on the transfer of post-operative care. Example:** Repair of ruptured musculotendinous cuff (e.g. rotator cuff) open; acute must be submitted as CPT® code 23410-54 with the date of service the surgery was performed. This portion of the procedure will be reimbursed to the operating physician at 70% of total fee for the rotator cuff repair.

- A physician providing only the postoperative component of a global surgical package (with another physician performing the surgical procedure) must attach modifier 55 to the surgical procedure code. An E/M visit code is inappropriate. **Note: The physicians involved in such care must first agree on the transfer of post-operative care. Example:** Repair of ruptured musculotendinous cuff (e.g. rotator cuff) open; acute must be submitted as CPT® code 23410-55 with the date of service the surgery was performed. This portion of the procedure will be reimbursed to the non-operating physician at 20% of total fee of the rotator cuff repair.

- When more than one physician provides post-discharge services included in the global package, the post-discharge care payments must be divided based on the number of days that each physician provides care. Note: **The physicians involved in such care must first agree on the transfer of post-operative care.** The use of an E/M visit code is inappropriate. **Example: Physician A**-(30 days post-operative care or one-third of the follow-up care) Repair of ruptured musculotendinous cuff (e.g. rotator cuff) open; acute must be submitted as CPT® code 23410-55 with the date of service the surgery was performed and a note stating date span the care was provided reported on a hard copy CMS 1500. This portion of the procedure will be reimbursed to the provider at 6.67% of total fee for the rotator cuff repair. **Physician B**--(60 days post-operative care or two-thirds of the follow-up care) Repair of ruptured musculotendinous cuff (e.g. rotator cuff) open; acute must be submitted as CPT® code 23410-55 with the date of service the surgery was performed and a note stating date span the care was provided reported on a hard copy CMS 1500. This portion of the procedure will

be reimbursed to the non-operating physician at 13.33% of total fee for the rotator cuff repair.

Note: While the current increase in these denials resulted from the implementation of the BWC automated edit for Global Surgical Care, it is not a new BWC policy. This edit is a medical billing industry standard which should be a current part of the MCO bill review process. Therefore, denials of submitted bills must be handled in accordance with normal MCO bill processing protocols.