
N E W S

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Recent Information on CPT and ICD-9 CM Codes for Cardiothoracic Surgeons

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CT Global Surgical Package; Coding Workshops

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-Keith Naunheim, M.D.,
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CARDIOTHORACIC GLOBAL SURGICAL PACKAGE

One of the most confusing tasks of cardiothoracic surgery is determining which services can be reported in addition to the main procedure(s). The global surgical package and the National Correct Coding Initiative (NCCI) are essential when deciding which codes can and should be reported. To further confuse the issue, many payers have different definitions of the global surgical package and different codes that may be bundled depending on which guidelines they follow.

Global Surgical Package
Medicare's definition of the global surgical package is the most widely used. Medicare defines the global surgical package in the *Medicare Claims Processing Manual* (pgs. 100-4, Chapter 12, Section 40.1, crosswalked from the *Medicare Carriers Manual*, Publication 14-3, Section 4820). Global or postoperative periods are assigned to each surgical procedure. The postoperative periods for which the global package definitions apply include the codes with a designation of a 0 (zero), 10(ten), or 90(ninety)-day global period.

Codes with a 0 or 10-day global period are considered either minor surgical procedures or endoscopies. A 0-day global period includes the day of the procedure only. A 10-day global period includes the day of the procedure and 10 days after the procedure. Codes with a 90-day global period are considered major surgeries where the global period includes the day before the procedure, the day of the procedure, and 90 days after the procedure. Codes with a ZZZ global period are also surgical procedures, and are considered add-on codes that are always billed with another service. There is no postoperative work included in the fee schedule for the payment of the ZZZ codes, as the global payment for a code with a ZZZ global period is included in the payment for the primary code. The components of the Medicare global surgical package that are considered part of the payment to the physician who performs the surgery include:

- **Preoperative Visits** – Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures, and the day of surgery for minor procedures
- **Intra-operative Services** – Intraoperative services that are normally a usual and necessary part of the surgical procedure

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- **Complications Following Surgery** – All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications that do not require additional trips to the operating room
- **Postoperative Visits** – Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery
- **Postsurgical Pain Management** – By the surgeon
- **Supplies** – Except for those identified as exclusions
- **Miscellaneous Services** – Items such as dressing changes, local incisional care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, splints, insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes

Services that are **not** included in the global surgical package include:

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. For Medicare, this policy only applies to major surgical procedures. The initial evaluation is always included in the allowance for a minor surgical procedure.
- Services of other physicians except when the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge

summary, hospital record, or ASC record.

- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery
- Treatment for the underlying condition or an added course of treatment that is not part of normal recovery from surgery, for example: a patient has a problem with arrhythmia in the global period of a CABG and returns to OR for permanent pacemaker placement; report the appropriate pacemaker insertion code with Modifier - 79 and a different diagnosis.
- Diagnostic tests and procedures, including diagnostic radiological procedures
- Clearly distinct surgical procedures during the postoperative period that are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure.
- Treatment for postoperative complications that requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's

condition was so critical there would be insufficient time for transportation to an OR).

- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- For certain services performed in a physician's office, separate payment can no longer be made for a surgical tray (code A4550). This code is now a Status B and has not been a separately payable service since January 1, 2002. However, splints and casting supplies are payable separately under the reasonable charge payment methodology.
- Immunosuppressive therapy for organ transplants
- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

In order to help physicians and their coders identify those services that are considered part of the global surgical package, the STS has developed a list of services that would typically be considered as part of the global surgical package for pre-, intra-, and post-operative services. This list is not all-inclusive. Although it is directed primarily at the 90-day global cardiothoracic procedures, most of the lists also extend to the 0 and 10-day global periods as well.

[See *Manual*, 100-4, chapter 12, section 40.1(a)(b)].

Pre-operative services included in the cardiothoracic surgical package (services provided the day of or the day before the procedure)

- Additional visits **after** the decision for surgery is made

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- Pre-operative H&P, unless it is the service where the decision for surgery is made

Intra-operative services included in the cardiothoracic surgical packages (if services are provided during the operative session)

- Insertion of lines/catheters/cannulas for access or monitoring purposes (e.g., Swan Ganz catheter insertion, arterial line insertions)
- Repair of cannula / line sites (if related to the surgery)
- Chest tube insertion/removal
- Foley catheter insertion/removal
- Temporary pacing wire insertion/removal
- Post-operative pain management by the surgeon (e.g., insertion of pain pumps, injection/ligation intercostal nerves)
- Checking patency of grafts (regardless of the method used)
- Insertion of wound vacs for wound care/management
- Access to the operative site (i.e., cannot separately report the approach such as thoracotomy, thoracoscopy, sternotomy, etc.)
- Closure of the surgical site (layered closure, suturing, bandages)
- Lysis of adhesions to obtain access to the surgical field
- Atrial fibrillation/cardioversion

Post-operative services included in the cardiothoracic surgical package (services provided after the surgery)

- Discharge day management
- Re-admission to the hospital for treatment of a complication of the original procedure

- Follow-up visits in the hospital or office for routine care or treatment of complications related to the original procedure
- Critical care to treat a complication of the original procedure
- Surgical trays
- Post-operative line changes
- Care of wound infections*
- Leg hematoma*
- Atrial fibrillation or cardioversion*
- Chest tube insertion/removal*
- Pleural effusion / thoracentesis*
- Temporary pacemaker insertion / removal*
- Closure of sternum*
- Buried sternal wire removal*
- Tracheostomy placement/ closure*
- Bronchoscopy, aspiration*

*Indicates services that are billable if the treatment requires a return to the OR, or a special procedures room, Modifier -78 (return to the OR for a related procedure during the post-operative period) should be appended to the correct CPT procedure code.

Tips for reporting services and the global surgical package:

- If the decision for surgery is made the day of or the day before a 90-day global procedure, the appropriate level and category of E/M service should be reported with modifier -57 (decision for surgery).
- Treatments of complications that require a return trip to the operating room are separately billable and should be reported using the appropriate CPT code and appending modifier -78 (return to OR).
For example: 3 days post-op a patient is taken back to the OR for bleeding. This should be reported using code

35820-78 – Exploration for postoperative hemorrhage, thrombosis or infection, chest.

- Payment for the -78 modifier should be at the intra-operative amount for the procedure. CT codes with a 90-day global generally reimburse 76% - 84% of the value for cardiothoracic procedures, CT codes with a 10-day global reimburse 80% of the value and codes with a 0-day global reimburse at full value. The pre-, intra-, and post-operative percentages are assigned by CMS by CPT code.
- Additional procedures performed during the same operative session as the original surgery to treat complications which occur during the same operative session as the original surgery should be reported using the appropriate CPT code and paid according to the multiple surgeries rule. If the patient is returned to the OR after the initial operative session, but on the same day as the original surgery for one or more additional procedures as a result of complications from the original surgery, the complications rules apply (must append modifier -78) to each procedure required to treat the complications from the original surgery. The multiple surgery rules would **not** apply.
- If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for bilateral

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procedures that are required as a result of complications from the original surgery, then the complications rules would apply. The bilateral rules would not apply. For procedures that are **unrelated to the original procedure**, the appropriate CPT code should be reported with modifier -79 (unrelated procedure or service by the same physician during the postoperative period) along with a different diagnosis from the original surgery (for example: a patient has a CABG, develops endocarditis, and requires aortic valve replacement (report 33405 -79), or patient develops a lung abscess and has to have a right upper lobectomy (report 32480 -79).

- For E/M services that are **unrelated to the original procedure**, the appropriate level and service of E/M service should be reported with modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period) along with a different diagnosis from the original surgery.
- For a staged or related procedure, modifier -58, (staged or related procedure or service by the same physician during the postoperative period) the appropriate CPT code for the first procedure, should be reported and then the second CPT code should be reported as appropriate. Modifier -58 should be appended to the code that would be in jeopardy of being denied.

- Modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) is generally used to pull an E/M service out of the global for minor procedures where significant counseling or coordination of care occur outside the typical scope of the procedure is provided. It is also used to report the decision for surgery for a minor (0 or 10-day global) procedure. A different diagnosis is not required to support the -25 modifier.

As indicated, the Correct Coding Initiative (CCI) bundling edits should be considered in addition to the global surgical package when reporting services. It is important to recognize that for Medicare, the CCI policy allows carriers to detect instances of fragmented billing or certain intra-operative services and other services furnished on the same day as the surgery that are considered components of the surgical procedure and subsequently, included in the global surgical fee. When both the CCI and global surgery edits apply to the same claim, carriers will first apply the CCI edits, then they will apply the global surgery edits. It is also important to recognize that not all of the global surgical components are captured in the CCI edits. The NCCI will be discussed in detail in the next edition of the Coding Newsletter.



CODING WORKSHOP

The next STS Coding Workshop will be held October 8-9, 2004 at the Crystal City Marriott in Arlington, VA. A registration form has been included with this Coding Newsletter. Please visit the STS Web site www.sts.org for program information. Topics include E/M Coding, Appeals, RUC Process, a hands-on coding session, and

break-out coding sessions for congenital, adult cardiac, general thoracic and vascular coding.



The material presented herein is, to the best of our knowledge, accurate and factual to date. The information and suggestions are provided as guidelines for coding and reimbursement and should not be construed as organizational policy. The STS/AATS disclaim any responsibility for the consequences of actions taken, based on the information presented in this newsletter.

CODING HOTLINE ASSISTANCE AVAILABLE FOR STS MEMBERS

The STS Coding Hotline is available to assist STS/AATS members and their staff with coding questions. You may ask questions via phone at 720-946-4817, Fax at 720-946-4816, or e-mail them to: juliepainter@grandsuites.com, or via mail. Please limit operative notes to one per month per physician. All requests must include the physician's name, STS or AATS membership number, and a phone number. All answers will be provided via a return phone call.



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