Global Visits, 99024, and MACRA: 3 Things You Should Think About and Lose Sleep Over But Probably Do Not

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PRACTICE **POINTS**

- Global period refers to payment for performance of a procedure and can be either 0 (000), 10 (010), or 90 (090) days. Most codes used by dermatologists fall under global periods of 0 and 10 days.
- Modifiers can be used if you perform other activities on the same day as the procedure or during the global period if those other activities are unrelated.
- *Current Procedural Terminology* code 99024 allows you to document for the billing side of the practice that the patient was there for a postoperative visit and may be a useful way to let payers know the visit occurred.

How does the global period affect dermatologists?

Global period is a term used to describe what is included in the payment for performance of a procedure using *Current Procedural Terminology (CPT)* codes. These global periods can either be 0 (000), 10 (010), or 90 (090) days. In dermatology, we have all three. Most codes used by dermatologists fall under global periods of 0 and 10 days, while 90-day codes are used for all adjacent tissue transfers and split- and full-thickness grafts. In documents listing global periods for *CPT* codes,[1] you also may see "XXX" when the global period concept does not apply to a particular code, "YYY" when the payer decides on whether a global period applies and what it will be, and "ZZZ" when a certain code is an add-on to another service and is therefore included in the global period for that service.

The contents of a service are defined by the global period. Although the procedure itself is an obvious component, *CPT* codes with a global period of 000 (eg, biopsy of a skin lesion, simple repairs) have no preoperative or postoperative periods, and an evaluation and management (E&M) service usually is not payable if it was done in relation to the procedure. If the patient returns the following day for any reason, including concerns about the procedure itself, these visits may be reported separately.

For *CPT* codes with global periods of 010 (eg, excisions, intermediate and complex repairs, destructions), there also is no preoperative period and a visit on the day of the procedure generally is not payable as a separate service. The day of the procedure and the 10 days after are included in the global period, and any visits relating to the procedure on that day and the 10 days following the procedure are not payable separately. Typically, the value of one 99212 or 99213 E&M visit is included in the payment for the procedure.

For *CPT* codes with global periods of 090, the day before the procedure, the day of the procedure, and 90 days following the procedure are all included. Typically, more than one established patient visit along with hospital management and discharge planning where deemed necessary by the Centers for Medicare & Medicaid Services (CMS) are included, which seems straightforward, but there is a sort of paradox here. An initial evaluation by the surgeon who determines the need for the 090 code (by definition, 090 means major surgery and major surgery means 090) can be separately reported for E&M using modifier -57

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(decision for surgery), which means the surgeon seeing the hot abdomen in the emergency department can report an E&M code in addition to the procedure, as can the surgeon who decides to repair a defect after removal of a skin tumor with a flap or graft. The same is not applicable if one performs a simple repair (included with benign or malignant excisions) following Mohs micrographic surgery or an intermediate or complex repair after any form of skin cancer removal. In any event, you are making a decision about what repair is best for the patient and sharing that with him/her while obtaining patient consent, but only 090 codes allow the capture of the decision to perform the procedure.

Which modifiers can you use on the same day as a procedure during the global period?

All is not lost if you perform other activities on the same day as the procedure or during the global period if those other activities are unrelated, which means complications of the procedure cannot be separately reported. If the unrelated cognitive work is reported on the day of a procedure with an E&M code, it should be accompanied by modifier -25 (significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day of the procedure or other service). If you have an E&M visit unrelated to the procedure within the global period, report it using modifier -24 (unrelated E&M service by the same physician or other qualified health care professional during a postoperative period).

If you perform another procedure on the same day as the primary one, you can use modifier -51 (multiple procedures) to let the payer know you provided other services that are separately reportable. If you do multiples of the same procedure, use modifier -59 (distinct procedural service) to let the payer know that you indeed did multiple procedures and did not submit a typographical error. Modifier -59 also is used when you perform a pair of procedures on separate and distinct lesions that would be disallowed by Mutually Exclusive Edits if done on a single lesion. For example, if you perform a biopsy of a lesion and immediately curette it, you should wait for the pathology report; if the lesion is malignant, only the destruction should be reported, and if it is benign, the only medically necessary service was the biopsy. When biopsy and curettage are performed on 2 separate lesions on the same date of service, payer software will disallow the biopsy charge unless a -59 modifier is attached to indicate that the biopsy was performed on a separate lesion. Medicare has introduced the -XS modifier, which is planned to be phased in to replace the -59 modifier for Medicare patients,[2] if and when the CMS sets up their systems to accept the modifier.

If you repeat a procedure during the global period (eg, reexcision for a positive margin), it is appropriate to use modifier -58 (staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period). If an unrelated procedure is performed during the global period, such as removing another lesion at a different site, modifier -79 (unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period) lets you report it.

There are 2 available modifiers that you might think twice before using. Modifier -76 (repeat procedure or service by same physician or other qualified health care professional) may be used if, for example, a wound opens and you have to sew it up again. The more common usage is more pedestrian; a second electrocardiogram reading on the same day is a common use.[3] Modifier -78 (unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period) is used when something goes awry, such as an aneurysm repair that is bleeding postoperatively, necessitating a trip back to the operating room.[4]

How might these modifiers be used in dermatology? One example may be if a wound dehisces or needs to be seen for a bleeding issue that might necessitate opening and exploring the wound; if a patient has one of these problems after fixing the plumbing and hits himself with a wrench, use of these modifiers is reasonable. On the other hand, if the patient is waiting in your office to be picked up and the problem happens, using these modifiers may not be the wisest thing to do. Let common sense prevail!

What is *CPT* code 99024?

Likely a code you have never used in your private office, the descriptor for 99024 states "postoperative follow-up visit, normally included in the surgical package, to indicate that an E&M service was performed during a postoperative period for a reason(s) related to the original procedure," which translates to "here for an included visit so why am I billing this and having the cost of a claim with no reimbursement?" Why indeed. You may be using it as a space holder—one more check and balance so no patient leaves the office without a superbill or its electronic equivalent being submitted to your billing staff—or you may simply never use it. The CMS is interested in it as a way to see if the visits embedded in

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global periods actually take place. This is especially important as CMS is legally mandated under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)[5] to see if these visits actually take place.[6] There are billions of dollars paid out for visits that are part of the global package and this code is one way the government may track them. If you are not using this code at all, you might consider it, even if you do not submit a claim. Your staff will know you did not forget to report a service and the reporting of the code by you internally and it lets you document for the billing side of the practice that they were there and a code report has been performed and not simply forgotten.

Final Thoughts

Following this discussion of global periods and *CPT* code 99024, you may be wondering why you get paid what you do and how the visits all link together. The buzzword is *intensity*, and we will explore that concept and IWPUT (intraservice work per unit of time), which I have coined as meaning "I Will Persevere Until Then," in the next column.

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