**SPECIALTY TIP #12**

**General Surgery**

**The Basics**

The global surgical package includes (per Medicare):

- Pre-operative visits after the decision is made to operate.
  - For major procedures, this includes pre-operative visits the day before the day of surgery;
  - For minor procedures, this includes pre-operative visits the day of surgery;
- Intraoperative services that are normally a usual and necessary part of a surgical procedure;
- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room;
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery;
- Post-surgical pain management by the surgeon; (Per Correct Coding Initiative – “unless separate, medically necessary services are required that cannot be rendered by the surgeon”. Therefore, any post-op pain management needs to be requested/ordered in the medical record).
- Supplies, except for those identified as exclusions; and
- Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Billable services *not included* in the global surgical package include:

- Initial consultation or evaluation by the surgeon to determine the need for major surgeries;
  - This is billed separately using the modifier -57 (Decision for Surgery). This visit may be billed separately only for major surgical procedures;
- 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 which is *not part of normal recovery* from surgery;
- Clearly distinct surgical procedures that occur during the post-operative period which are not re-operations or treatment for complications;
- Treatment for post-operative complications requiring 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;
- Immunosuppressive therapy for organ transplants; and
- Critical care services (Current Procedural Terminology (CPT) 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.

**NOTE:** The above information is applicable to professional services. Different types and places of services may affect the global package concept (i.e., ASC facility billing).

**NOTE:** Section II.B.4 of Medicare’s 2015 Physician Fee Schedule Proposed Rule includes a plan to eliminate 10- and 90-day global periods for all CPT® procedure codes, beginning in 2017. If adopted, the plan would radically change how the Centers for Medicare & Medicaid Services (CMS) values procedures, as well as how it pays for post-procedure follow up.
Documentation

In order to avoid miscoding, there are documentation practices that would aid coding to identify how to code and/or add modifiers to get appropriate reimbursement for your services.

- Are you seeing the patient in consultation for your opinion for surgery, seeing the patient to obtain the history, complete an exam, and determine the appropriateness and assess the effectiveness for surgery (H&P visit-usually ≤ 30 days prior to surgery), or are you seeing the patient as a brief pre-operative assessment for surgery (decision already made-pre-op)?  (See Specialty Tip #8 for some insight here.)
  - Per CMS: “Evaluation/Management (E/M) services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery. Therefore, these services may be billed and paid separately.” (-57 modifier for major surgery)
- Provide adequate history to identify any former surgeries or conditions affecting treatment.
  - Often it is difficult to differentiate whether the current surgery is the initial procedure or is this surgery:
    - A repeat surgery (-76 modifier if same surgeon, -77 modifier by a different surgeon),
    - A planned, staged procedure (-58 modifier if within the postoperative global period),
    - For a different condition (thereby starting the global “clock” for a different condition, -79 modifier),
    - A correction of a defect (different diagnosis noting a complication), or
    - An unplanned return to the operating room for a related procedure (-78 modifier).
  - When was the last surgery?
    - Is this within the global period of the previous surgery?
  - What condition has prompted the current surgery?

- Details DO matter!
  - Lesions
    - ALWAYS document the size, number, and location of EACH lesion
    - Excision is defined as full-thickness including simple (non-layered closure)
      - For excisions requiring more than a simple closure, be sure to document in detail (complex closure, adjacent tissue transfer, etc.)
    - Size is determined by measuring the greatest clinical diameter plus the margin
      - Do not depend on the path report for size, it will shrink thereby defaulting to a lesser value
      - If no size is given, the coding must default to the lesser code
    - If known, document type of lesion (malignant, benign, epidermal, etc.)
      - Should we look for a path report? Note on op report if specimen is sent to path.
  - Debridement
    - Report depth using the deepest level of tissue removed
      - For multiple wounds, report depth of EACH wound
      - If depth is not noted, the code will default to the lesser code
    - For debridement of extensive eczematous/infected skin, report % of body surface
  - Burns
    - List percentage of body surface area involved and depth of burn
  - Repairs (closure)
    - Simple repair – superficial, one-layer repair of the epidermis, dermis, or subcutaneous tissues. Wounds treated with tissue glue or staples qualify as a simple repair even if they are not closed with sutures.
    - Intermediate repair - when layered closure of one or more of the deeper layers of subcutaneous tissue and superficial fascia, in addition to the skin, require closure. Intermediate repair is also reported for single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter.
    - Complex repair - The physician performs complex, layered suturing of torn, crushed, or deeply lacerated tissue. These procedures include the repair of wounds requiring more than layered closure, such as extensive undermining, stents, or retention sutures. They may also include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions. The physician may perform scar revision, which creates a complex defect requiring repair. Stents or retention sutures may also be used in complex repair of a wound.
Below are a few points to keep in mind:

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Documentation Requirements</th>
</tr>
</thead>
</table>
| Abdominal Surgeries such as: Appendectomy Cholecystectomy | Differentiate between:  
- Approach:  
  - Open  
  - Percutaneous  
  - Endoscopic  
  • Document if incidental appendectomy |
| Hernia Repair |  
- Site:  
  - Abdominal wall  
  - Diaphragm  
  - Femoral  
  - Inguinal  
  + With or without graft or prosthesis  
  + Laterality:  
  - Right  
  - Left  
  - Bilateral  
  • Approach:  
  - Open  
  - Percutaneous  
  - Endoscopic |
| Lysis of Adhesions | Specify each organ or body part released, for example:  
- Greater omentum  
- Lesser omentum  
- Mesentery |
| Debridement |  
- Excisional or Non-excisional debridement  
- Depth of debridement:  
  - Skin  
  - Subcutaneous tissue  
  - Fascia  
  - Muscle  
  - Bone |
| Lymph Node Removal |  
- Differentiate between removal of:  
  - One or more lymph nodes  
  - Open or by needle |

Evaluation and Management

We will be covering the fine points of Evaluation and Management documentation in the next specialty tip (#13). This is just a reminder that your documentation defines the code set to be used (Consult vs Visit, etc.) All initial visits (Consults, H&P) with the patient require a history, physical evaluation, and documentation of medical decision making. The only exclusion would be a trauma evaluation where the acuity of the patient’s urgent clinical condition would preclude these 3 key components.

Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery or critical care services (CPT codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attention of the physician may be billed.

Notice that the visit must clearly indicate the critical care is a significant, separately identifiable E&M service that is unrelated to the surgery above and beyond the usual pre- and post-operative care associated with the procedure performed in order to not be considered a component of the surgical package global care. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition and requires the full attention of the physician.

Diagnosis

Diagnoses are the mechanism that supports the medical necessity for treatment. Every procedure code has attached to it (by insurance companies) a number of diagnoses that supports the need for the procedure. Should a primary diagnosis fall outside of that “bucket” of codes, the claim is deleted from the automatic queue and requires further review. Based on that review, there may be a denial or a request for further information. Either way, there is created a time delay in payment for your services.

• If applicable, always state laterality
• Detail anatomical locations
• Detail approaches (open, endoscopic, closed)
• State whether the patient is in the treatment (surgery, Emergency Department, etc.) or healing phase (most follow-up visits) or is this a late effect/sequela of an injury?
• State acute or chronic, old injury, any descriptive wording that help to illustrate the condition
• State any “due to” or precipitating conditions
• Include comorbid and relevant conditions that impact decision making or complicate surgery

• Document trimester for all pregnant patients and number of weeks gestation in all settings (this impacts the code set used)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Additional Information Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain</td>
<td>• Generalized? (R10.84) • Acute abdomen? (R10.0) • Tenderness? (10.8-) • Colic? (R10.83) • Pelvic and Perineal? (R10.1) • Specify Quadrant for pain or tenderness: - Right or left - Upper or lower - Periumbilic Epigastric - Generalized</td>
</tr>
<tr>
<td>Abscess</td>
<td>• Site specific • Latenlarity, when applicable</td>
</tr>
<tr>
<td>Alcohol Dependence – (Applicable to many dx codes)</td>
<td>• Use, abuse, or dependence of alcohol? • Blood alcohol level if applicable? • With other related disorders (withdrawal, intoxication, in remission, mood disorder, etc.)?</td>
</tr>
<tr>
<td>Anemia</td>
<td>• Acuity: - Acute, Chronic, Acute on chronic • Due to? • Aplastic? • Type (large selection to choose from): - Hemorrhagic (Acute or chronic) - Idiopathic - Iron Deficiency - Nutritional - Blood Loss, etc.</td>
</tr>
<tr>
<td>Appendicitis</td>
<td>• Acute, chronic, or recurrent? • With or without generalized or localized peritonitis?</td>
</tr>
<tr>
<td>Bleeding, post-op</td>
<td>• Specific to intraoperative or postprocedural</td>
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### ICD-10 SPECIALTY TIPS

<table>
<thead>
<tr>
<th>Specialty / Location</th>
<th>Description</th>
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</table>
| **Cancer**           | - Specific to system / location.  
- Site? Laterality when applicable?  
- Asks for additional code to identify alcohol abuse and/or dependence  
- Detail when a patient has presented for a specific treatment related to the neoplasm (e.g., surgical removal, chemotherapy, immunotherapy, radiation therapy)  
- Document morphology:  
  - Malignant (Primary)  
  - Secondary  
  - Benign  
  - In situ  
  - Uncertain behavior  
  - Unspecified behavior |
| **Cholecystitis**     | - Document acuity:  
  - Acute, Chronic, Acute on chronic |
| **Cholelithiasis**    | - Differentiate specific site:  
  - Calculus of gallbladder  
  - Calculus of bile duct  
  - Calculus of gallbladder and bile duct  
- Specify presence of obstruction:  
  - With obstruction  
  - Without obstruction  
- Document presence of cholecystitis and/or cholangitis |
| **Complications:**   | - Internal Device, Implant, and Graft  
- Mechanical/Hardware  
- Infection or Inflammation  
- If a complication of surgery, state whether:  
  - Intraoperative or postoperative  
- Specify nature of the complication:  
  - Pain  
  - Stenosis  
  - Embolism  
  - Leakage  
- Specify presence of obstruction:  
  - Obstruction  
  - Perforation  
  - Protrusion  
  - Stitch dehiscence |
| **Foreign Body**      | - ICD10 is specific to food, gastric contents, other foreign objects or unspecified foreign body  
- With laceration or puncture wound?  
- Causing acute reaction?  
- Location?  
- Complication of?  
- Retained foreign body?  
- Episode of Care: Initial or subsequent encounter? Or Sequela? |
| **Hernia**            | - Specific site:  
  - Inguinal  
  - Femoral  
  - Umbilical  
  - Ventral  
  - Diaphragmatic  
  - Other abdominal  
- Document laterality:  
  - Right  
  - Left  
  - Bilateral  
  - Recurrent  
  - Reducible  
  - Incarcerated  
- Specify presence of gangrene:  
  - With gangrene  
  - Without gangrene  
  - With obstruction  
  - Without obstruction |
| **Lipoma**            | - Anatomical location detail?  
- BMI needed.  
- Any additional comorbid conditions or complications? |
| **Morbid Obesity**    | - Document type, such as:  
  - Saddle  
  - Septic  
- Document cor pulmonale if present and whether it is:  
  - Acute or Chronic  
- Specify if:  
  - Chronic (still present) vs. Healed/old  
  - Note that “history of PE” is ambiguous |
| **Pulmonary Embolism**| - Systemic type or causal organism?  
- Do NOT use the term UROSEPSIS (consider UTI with Sepsis)  
- Present on admission vs. hospital acquired?  
- Document type:  
  - Circulatory failure related to Sepsis and/or Septic Shock  
  - Severe Sepsis with specific related acute organ dysfunction, when applicable  
- Document state of dependence:  
  - In remission  
  - With withdrawal  
  - Without withdrawal |
| **Sepsis**            | - Laterality?  
- Specific anatomical location?  
- With bone necrosis, exposed fat layer, muscle necrosis, or skin breakdown only? |
| **Tobacco Use Disorder** | - Document type:  
  - Cigarettes  
  - Chewing tobacco  
  - Other  
- Delineate between:  
  - Tobacco use/abuse  
  - Tobacco dependence  
  - History of  
  - Exposure to  
- Document state of dependence:  
  - In remission  
  - With withdrawal  
  - Without withdrawal |
| **Ulcer of Skin**     | - Document type:  
- Specific anatomical location?  
- With bone necrosis, exposed fat layer, muscle necrosis, or skin breakdown only? |

The information provided is only intended to be a general summary and not intended to take place of either written law or regulations.