CPT Surgical Package Definition

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The concept of a global payment for surgeries and procedures represented by a Current Procedural Terminology (CPT®) code was introduced with the implementation of the Resource Based Relative Value System (RBRVS) in 1992. This concept describes the components of the global surgical package.

The global surgical package concept in CPT includes the pre-operative, intra-operative, and post-operative surgical services. Certain pre-operative services, performance of the surgical procedure (including procedures that are an integral component of a procedure), and **all uncomplicated follow-up care** are included in the CPT surgical package. This article provides an overview of the CPT surgical package definition, describes evaluation and management (E/M) services from a CPT and Centers for Medicare and Medicaid Services (CMS) perspective, and offers additional clarification of services that may or may not be reported separately.

For the CPT ® 2015, the definition of global surgical package was changed. As indicated in the Surgery Guidelines (page 62 of the CPT Professional 2015), the CPT surgical package is defined as follows:

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By their very nature, the services to any patient are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services 'included' in a given CPT surgical code, the following services related to the surgery when furnished by the physician or other qualified health care professional who performs the surgery are included in addition to the operation
per se:

- Evaluation and Management (E/M) service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical)
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians or other qualified health care professionals
- Writing orders

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- Evaluating the patient in the postanesthesia recovery area
- Typical postoperative follow-up care

To reiterate, the concept of a 'surgical package' refers to a combination of services provided by the physician once the decision for surgery is reached. The elements of the surgical package vary widely but are considered inherent in a readily identifiable CPT procedure code. Therefore, it is important to understand which components of a procedure may or may not be reported individually. The reporting exception(s) include additional services performed at the time of or subsequent to the definitive surgical procedure(s) due to complications, exacerbations, recurrence, or the presence of other disease(s) or injury(ies).

Reporting Evaluation and Management (E/M) Services

The physician or other qualified health care professional work of performing and preparing the history and physical (H&P) is reported differently, when it is part of the surgical package. The following three clinical examples illustrate the following two scenarios.

Scenario 1

When the decision for surgery occurs the day of or the day before a major procedure and includes the preoperative E/M services, this visit is separately reportable. Modifier 57, Decision for Surgery, is appended to the E/M code to indicate that this is the decision-making service, not the H&P alone.

Example

A patient is seen in the emergency room with acute appendicitis. The surgeon sees the patient, makes a diagnosis, and reaches a decision to perform surgery. The patient then promptly undergoes a laparoscopic appendectomy.

How to Code

Report CPT code 99222 (or similar initial emergency department code) with modifier 57, along with the appropriate appendectomy code: 99222-57 and 44970.

Scenario 2 (Examples 1 and 2)

When the surgeon sees a patient and makes a decision for surgery, and the patient returns for a visit where the intent of the visit is the preoperative H&P, and this service occurs in the interval between the decision-making visit and the day of surgery, regardless of when the visit occurs (eg, 1 day, 3 days, or 2 weeks), the visit is not separately reported because it is included in the surgical package.

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Codify by AAPC

Example 1

The surgeon sees the patient on March 1 and makes a decision for surgery. Surgery is scheduled for April 1. The patient returns to the office on March 27 for the H&P, consent signing, and any needed clarification.

How to Code

The E/M services on March 1 are reported with modifier 57, Decision for Surgery. The visit on March 27 is not reported because it is the preoperative H&P visit and is included in the surgical package.

Example 2

A patient is seen in the physician's office for evaluation of perirectal fluctuance. Evaluation suggests the rectal abscess will need to be drained. The patient is taken to the operating room for the procedure.

How to Code

The appropriate office or other outpatient E/M level visit is reported with modifier 57 appended. However, if the patient is admitted or observed in the hospital, then the appropriate E/M code would be 99218. Modifier 57 would be appended, and the operative procedure would be reported as well.

Post-Procedure Follow-up Care

The follow-up care for diagnostic and therapeutic procedures is separately addressed in the CPT Surgery Guidelines. Diagnostic procedure follow-up 'includes only that care related to recovery from the diagnostic procedure itself. Care of condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.'

Uncomplicated Postoperative Follow-up Care

Uncomplicated postoperative follow-up care for therapeutic surgical procedures 'includes only the care that is usually a part of the surgical service. Complications, exacerbations, recurrence, or the presence of other disease or injuries requiring additional services should be separately reported.' This additional reporting may include:

- Performance of other diagnostic or therapeutic procedure(s) or service(s)
- Performance of E/M service(s) (including critical care)
- Use of appropriate CPT modifier(s) to indicate that a service was performed during a postoperative period for a reason(s) related or unrelated to the original procedure.

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Example 1

A physician performs a surgical operation, and one week later the patient is seen in the physician's office for follow-up care related to the operation.

How to Code

The follow-up visit provided by the physician would not be reported separately. However, based on payer requirements for documentation purposes, CPT code 99024, Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure, from the Medicine section of the CPT code set, may be reported for this postoperative follow-up visit.

Example 2

A patient undergoes surgical excision of a suspicious breast mass on May 1. She returns to the office on May 5 for routine follow-up. The lesion is a benign fibroadenoma. Care includes a check of the incision and the breast, and a brief interval history. Results are discussed with the patient, and no additional management is required.

How to Code

This service is not billed separately because it includes care related to recovery from the procedure.

Example 3

A patient undergoes surgical excision of a suspicious breast mass on May 1. She returns to the office on May 5 for routine follow-up. Pathology report indicates the breast mass is benign. In addition to the routine care related to the excisional biopsy, the patient complains of pain and discomfort in the other breast. An E/M work-up is performed to evaluate those symptoms. A biopsy is scheduled for the following week.

How to Code

The appropriate E/M level of service code is reported with modifier 24, Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period, appended.

Third-Party Payer Global Surgery Definitions

The CPT surgical package definition does not provide a specific number of postoperative days in which follow-up care may take place. Services that are included in a surgical package may differ for each third-party payer.

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Minor Surgeries and Endoscopies

Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be appropriately reported in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Reporting a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status.
A postoperative period of 10 days applies to some minor surgeries. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, the major surgery is reported separately. Services by other physicians are not included in the global fee for minor procedures except as otherwise excluded.

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