The Global Surgical Package

One of the most important E/M billing questions in radiology is whether it is appropriate to charge for an E/M service provided in conjunction with a procedure. For example, should the radiologist submit an E/M code for examining a patient prior to an angiogram, or for seeing a patient in follow-up after a drainage procedure? In order to answer this question, it is necessary to understand what services are included in the payment for the procedure.

CPT® Surgical Package Definition

The Surgery Guidelines section of the CPT® manual states that the following services are included in a CPT® surgical code when “related to the surgery” and when “furnished by the physician or other qualified health care professional who performs the surgery”:

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

The guidelines do not define how long the postoperative period lasts. However, they state that the surgical package includes only “typical” postoperative follow-up care. The CPT® manual states, “Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services should be separately reported.”

Medicare Surgical Package

The Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare and Medicaid programs, has issued its own definition of the surgical package, which differs in some important respects from the CPT® definition. Medicare guidelines for global surgery are found in the following publications:

- Medicare Claims Processing Manual, Chapter 12, Section 40 (“Surgeons and Global Surgery”)
- National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 9 (“Radiology Services”)

The following page contains a listing, taken from the Medicare Claims Processing Manual, of the components that are included in the Medicare surgical package.
Consultations

The CPT® manual defines a consultation as “a type of evaluation and management service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient’s entire care or for the care of a specific condition or problem.”

Medicare does not recognize the CPT® consultation codes. However, physicians can submit claims to Medicare for consultations using other E/M codes. This section will review the Medicare guidelines for consult billing, followed by the CPT® guidelines for consultations, since some payors continue to reimburse for the consult codes.

Medicare Policy

The Medicare policy on consultations is outlined in the Medicare Claims Processing Manual, Chapter 12, Section 30.6.10. CMS has instructed that physicians should bill for consultations using an E/M code for the setting in which the consultation was provided.

Office/Outpatient: In the office or hospital outpatient department, the consultant should report the consultation using a new or established patient office/outpatient visit code (99201-99215), depending on the physician’s relationship with the patient. (The definitions of new and established patients are discussed in the next section of this Navigator®.)

Emergency Department: A consultation on an emergency department patient should be reported with the appropriate level of emergency department visit code (99201-99285). This rule applies even when the ED physician is also billing for an ED visit on the same patient. If the consultant admits the patient to the hospital, the consultant should bill only for initial hospital care, not for the ED visit.

Inpatient Hospital: In the inpatient hospital setting, the consultant should report the initial encounter with the patient using an initial hospital care code (99221-99223), even though the CPT® manual states that only the admitting physician can use these codes. CMS has instructed the admitting physician to apply modifier AI (Principal physician of record) to the initial hospital care code to distinguish the admitting physician’s service from the services of consultants and other physicians.
History

The first of the 3 key E/M components is the history, which consists of information obtained from the patient and/or family. A complete history consists of 4 parts:

These components will be reviewed in detail, followed by discussion of the various history levels.

Chief Complaint (CC)

The chief complaint is defined in the Documentation Guidelines as “a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.”

A chief complaint must be documented as part of every history, regardless of the level of service. This information is important in establishing the reason for the encounter and—in turn—the medical necessity for the encounter. Even if the reason for the encounter can be inferred by reviewing the rest of the medical record, it should still be clearly documented by the physician on each encounter.

The following are examples of appropriate documentation of the chief complaint:

- Consultation: “Thank you for asking me to see this patient in consultation regarding renal artery stenosis.”
- Hospital visit for patient who has an indwelling drainage catheter: “Draining pelvic abscess.”
- Office/outpatient visit post procedure: “Scheduled follow-up visit status post vertebroplasty.”
E/M Services by Nonphysician Practitioners

Many radiology practices use nonphysician practitioners (NPPs) to enhance the radiologists’ productivity by performing tasks that do not necessarily have to be done by a physician. This can be a good strategy; however, use of NPPs carries risks, particularly for practices that do not understand the Medicare requirements.

What is a Nonphysician Practitioner?

CMS defines an NPP as someone who holds one of several different credentials. Depending upon their training, education, and licensure, nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists can all be considered NPPs. CMS does not classify Radiologist Assistants (RAs) and Radiology Practitioner Assistants (RPAs) as NPPs. E/M services performed by these professionals will be discussed later in this chapter.

The Introduction to the CPT® manual refers to 2 different categories of professionals, defined in the boxes below.

**Physician or Other Qualified Health Care Professional**

“An individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.”

**Clinical Staff Member**

“A person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.”

Payor policy, state law, and facility policy will determine which category a particular type of professional falls into. But for Medicare billing purposes, an NPP is considered an “other qualified health care professional,” since the NPP can “independently report” his or her services. That is, claims for the NPP’s services can be submitted under the NPP’s provider number. Clinical staff, on the other hand, will include office nurses who are not NPPs, as well as technologists, RAs, RPAs, medical assistants, etc.

The CPT® manual states that for purposes of distinguishing between new and established patients, an NPP who is working with a physician is “considered as working in the exact same specialty and exact same subspecialties as the physician.”