# Patient Pre-optimization Quick Coding Guide

## CMS Definitions of Global Days and Included Services

| 0 days | 10 days | 90 days |
|---|---|---|
| No pre-operative period<br><br>No post-operative days<br><br>Visit on the day of procedure is generally not payable as a separate service | No pre-operative period<br><br>Visit on the day of the procedure is generally not payable as a separate service<br><br>Total global period is 11 days<br>➢Count the day of surgery and the 10 days immediately following the day of surgery | One day preoperative period (is included)<br><br>Day of the procedure is generally not billable as a separate service<br><br>Total global service is 92 days<br>➢Count 1 day before the surgery, the day of surgery, and the 90 days immediately following the day of surgery |

## Examples of Presurgical Patient Optimization

- Ensuring the patient is medically fit for surgery (reviewing consults, imaging, and lab results)
- Determining the appropriate location for surgery (IP, OP, ASC)
- Arranging preoperative rehabilitation services
- Perioperative management
- Discharge planning
- Infection screening
- Anticoagulation coordination

**Does not represent a comprehensive list*

## Appropriate Codes for Reporting Patient Pre-Optimization

| CPT Code | Description |
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| **Office or Other Outpatient E/M Services** | |
| **99212-99215** | *Office or other outpatient visit for the evaluation and management of an established patient*...<br><br>➢Medical decision making and time criteria varies by code. |
| **Notes:** | Guidelines for assigning medical decision making (MDM) credit under the current 2021 E/M guidelines for office services may limit the level of service when using MDM for code selection of an optimization visit. For example, if a provider using MDM to select a level of service takes credit for consideration of major surgery under the Risk element during an initial evaluation, it is not clear if the same credit can be assigned when the decision for surgery is finalized. **Using Time to determine the level of service for an optimization visit is reasonable and supported.** |
| **Example:** | Visit #1: A patient with severe knee arthritis refractory to non-operative measures returns to the office. Physical exam and radiographs indicate a total knee (27447, 90-day global) would be the best option and a unilateral knee placement (27446, 90-day global) is being considered. Comorbidities include |

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| | hypertension, unstable diabetes, and atrial fibrillation which requires an anticoagulant. Patient is sent to see her internist, endocrinologist, and cardiologist for pre-operative clearance consultations.<br><br>Vist #2: The patient returns to the office and the provider reviews all of the records and gets up-to-date laboratory values. If the findings from the clearance consultations and laboratory testing indicate the patient is able to proceed with surgery, the provider then proposes surgery as a definitive recommendation. The provider explains the specifics of the proposed procedure and initiates other presurgical optimization steps.<br><br>➢*Both of these visits are billable as an established patient office visit E/M code, with the level of the visit determined by the documentation (99212-99215, +99417, +G2212). The global period for the surgery will start the day before the operation. When the surgeon sees the patient the day of surgery prior to the operation that visit is **not** billable. This is because the preoperative time of that visit has already been valued in the 90-day global code (CPT 27447) as part of the pre-time package.* |
| **Prolonged Service With or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service** | |
| **+99417 (CPT)** | *Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)* |
| **+G2212 (CMS)** | *Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes*) |
| **Notes:** | CPT instructions allow prolonged services time on the date of the E/M encounter to be counted after the minimum range of the 99205 or 99215 service is met, but CMS requires that prolonged time is reported after the maximum required time for the primary service. |
| **Example:** | A provider spends 55-69 minutes (including face-to-face and non-face-to-face services) on the date of an optimization visit. Code +99417 could be reported in addition to code 99215.<br><br>➢For CMS, 70-84 minutes would be required in order to report +G2212 in addition to 99215. |

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| **Prolonged Service Without Direct Patient Contact** | |
| **99358** | *Prolonged evaluation and management service before and/or after direct patient care; first hour* |
| **+99359** | *Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)* |
| **Notes:** | ➢These codes include time spent providing indirect contact services by a physician or other qualified healthcare professional (QHP) in relation to patient management where face-to-face services have or will occur on a different date.<br>➢CPT instructions state that codes 99358 and 99359 cannot be used during the same session as codes 99202-99215, but in the September 2020 *CPT Assistant* the AMA stated that these codes can be reported for care related to office or other outpatient services that occurred on a different date.<br>➢In the 2021 Medicare Physician Fee Schedule CMS disagreed and stated they will not allow payment for codes 99358/99359 in relation to codes 99202-99215, even for services on a different date. Other payor rules may vary.<br>➢Time spent providing prolonged services apply to a given date (eg, single date of service), even when time is not continuous. The calculation of time would not include cumulative services provided over multiple dates.<br>➢The CPT coding rule for reporting time-based codes applies (ie. a unit of time is attained when the midpoint has passed). |
| **Example:** | A provider assessing a patient for surgery documents spending 35 minutes reviewing consultation reports from the internist and endocrinologist, along with laboratory, and imaging results, and formulating a plan for surgery. The provider would report code 99358, because greater than the midpoint requirement of one hour was achieved.<br><br>➢*At least 30 minutes is required to support code 99358.* |
| **Telephone Services** | |
| **99441-99443** | *Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment*;…<br><br>➢Time criteria varies by code. |
| **Notes:** | Payor policies for telephone E/M services may vary, particularly during a public health emergency. |
| **Example:** | A patient who lives a considerable distance away from the provider's office requests a telephone visit with the provider to discuss the outcome of their |

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| | presurgical clearance. The provider reviews the consultations and lab results with the patient and determines that the patient is an appropriate candidate for surgery. The call to discuss the perioperative plan and discharge management arrangements takes 30 minutes.<br><br>➢*Keep in mind, the CPT definition includes limitations for telephone services originating from or related to a visit within the previous 7 days and leading to an E/M service or procedure within the next 24 hours or soonest available appointment.* |

## Resources

- AAOS Now, May 2021, Coding for Patient Optimization Work in the Pre-surgical Period
- AAOS Webinars On Demand: TKA/THA RVUs Impacted by the 2021 Medicare Physician Fee Schedule Final Rule
- Current Procedural Terminology, 2021
- CMS Medicare Learning Network: *Global Surgery Booklet*, September 2018, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf.