Auto Casualty

Global Surgical Package Fraudulent Billing

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Sometimes the most innocuous conversations with family, friends and coworkers can lead to a major finding for medical billing fraud. Take the example of simply talking to your coworker in the next cube about a suspicious provider billing situation. To your surprise, you find out your coworker is having the same suspicion about the same provider on other auto first party claims. What ends up happening is a pervasive situation of intentional fraud uncovered by one conversation. This is exactly what occurred in identifying “Global Surgical Package Fraudulent” billing scenarios.

What is the Global Surgical Package?

Understanding what the Global Surgical Package concept is and how these procedures are presented in billing is an important aspect in finding this type of fraud. The global surgical package, also called ‘global surgery’ and sometimes ‘global surgical period,’ is a single payment for all care associated with a surgical procedure. It includes all necessary services normally furnished by a surgeon before, during and after a procedure. Medicare payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by a surgeon or by members of the same group with the same specialty. The global surgical package includes a global follow-up period whereby follow-up care is not to be billed. Follow-up office visits performed during the global follow-up period should not be billed or reimbursed separately. The length of the global follow-up period is specific to the surgical procedure code and varies according to the severity of the surgery and its level of complexity. There are three time periods used by Medicare to define the periods of which a global follow-up should be applied; and most timelines including the rules, have been adopted as a standard by most payors. The three time periods are outlined below:

- Zero days – for procedures like endoscopies
- 10 days – minor procedures
- 90 days – major procedures

The zero, 10 and 90-day timelines are an important factor of the global surgical package where the provider is unable to charge for certain services as they are included in the price paid for the surgical procedure itself. For our discussion, we will use the most complex global surgical package – 90 days. In actuality, the 90-day global surgical timeline, is really 92 days. This is because it includes specific charges the day prior to surgery, the day of surgery, and 90 days after the surgical procedure is performed. The following services are included in the 92-day timeline:

- Intra-operative procedures
- 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
- Supplies, except for those identified as exclusions
- 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

Knowing what is included in the global surgical package is key to finding billings that are not supposed to be charged for by the provider.

Identifying a Claim's Potential for Fraud

Discussing issues with family, friends and coworkers have the potential of driving an investigation further into data, and in the following case, it did. The conversation in this scenario involved an experienced insurer, who we will call Joe, and a family member of his who recently underwent surgery. Knowing that he has extensive background in medical coding, the family member, who we will call Jane, asked Joe a question regarding her healthcare bill. "Why have I been billed for all of my follow-up visits, yet not once seen a bill for my surgical procedure come in?" This question sent red flags to Joe, who then asked Jane if the provider was paid for the follow-up visits. Jane responded, "Yes." Jane had a spinal fusion that fell into the 90-day global surgical package. Confused as to why Jane had been billed having not surpassed the 90-day post-operative timeline parameter, Joe escalated questions and prompted an investigation into auto claims at his own employer. He was determined to see how prevalent billing for follow-up visits before the surgical procedure was billed out of their own payment system. A conversation like this encountered by someone less familiar with correct coding may have been dismissed as nothing more than a quirk in the provider's workflow. Luckily, Joe had many years of experience with medical coding and healthcare and was able to initiate a detailed investigation of claims data. What he found was that this kind of fraudulent practice had been occurring for several years without any indication. Unlike workers' compensation claims, the majority of auto casualty claims are paid retrospectively, and procedures are often not managed in pre-authorization – with the exception of New Jersey. Receiving follow-up office visit codes (99211, 99212, 99213, 99214, 99215) is not unusual and would essentially go under the radar as long as there is a compensable injury. Had the provider billed in a manner consistent with date of service, most bill review systems would recognize that a surgery was performed and that a global surgical package and follow-up billings would be applied. However, when the provider submits bills for payment out of date of service order, this indication becomes much more difficult. Even though the dates preceded the follow-up visits, billing the surgery after the follow-up visits would cause an insurer to pay for these visits separately. Providers that bill auto claims and "holds" the surgical procedure bill until after the follow-up period, should be reviewed. Just when you think you have heard it all, think again. When it comes to potential manipulation of billing codes, the scenarios are endless. Something as innocent as a simple conversation with a family member

can cause a review of data that may prove to be a fraudulent scenario. If recognizing this issue is not in a bill review system today, it will be tomorrow. To mitigate in the meantime, data queries can be written to look for these types of scenarios to initiate an investigation.

[1] Department of Health and Human Services, 2017



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