Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 2 Questions To Ask Yourself When Reporting Postoperative Infections

If you're treating Medicare and private-payer claims the same, you could forfeit $80 or more per claim

If you're including postsurgical infection care in the global surgical package of the primary procedure every time, you're missing out on legitimate revenue. To determine if you deserve additional reimbursement, ask yourself two questions:

Question 1: Who's the Payer?

Medicare treats postoperative complications, including infections, differently than insurers who follow CPT guidelines. Although both CMS (Medicare) and CPT guidelines indicate that the global surgical package includes "typical" postsurgical care, the two sources differ on what qualifies as typical - which means you must differentiate your claims depending on the payer you are billing.

"Basically, Medicare requires that a complication must be significant enough to warrant a return to the operating room before you may report a separate procedure," says **Eric Sandham, CPC**, compliance educator for **Central California Faculty Medical Group**, a group practice and training facility associated with the **University of California at San Francisco** in Fresno. CMS "Correct Coding" guidelines specifically state, "When the services described by CPT codes as complications of a primary procedure require a return to the operating room" you may report a separate procedure.

"But CPT guidelines are less strict," Sandham says, "and you may report some postoperative services during the global period, including treatment of infection, that the surgeon provides in the office." This means, for instance, that you could collect an additional $80 from private payers for a level-four established patient visit (99214) to deal with a patient's postoperative infection.

Here's the bottom line: If treatment of a postoperative infection requires that the surgeon return the patient to the operating room, you may report the procedure for either Medicare or private payers. If the physician can treat the infection in his office, however, you may only file a claim for those payers that follow CPT guidelines.

Question 2: Which Modifier Do I Need?

For both Medicare and private payers, you'll have to append a modifier to the appropriate CPT code to describe the physician's treatment of the postsurgical infection. "If the surgeon is returning to the operating room during the global surgical period of a previous procedure, the correct modifier is -78 (Return to the operating room for a related procedure during the postoperative period)," says **Sharon Tucker, CPC**, president of **Seminars Plus**, a consulting firm specializing in coding, documentation and compliance issues, in Fountain Valley, Calif. And, modifier -78 "indicat[es] that the service necessary to treat the complication required a return to the operating room during the postoperative period," according to CMS guidelines. The use of modifier -78 to indicate a return to the operating room applies to both private and Medicare payers.

For private payers to reimburse for in-office post-operative infection treatment during the global period, you should append modifier -24 (Unrelated evaluation and management service by the same physician during a postoperative period) to the appropriate E/M service code, says **Marcella Bucknam, CPC, CCS-P, CPC-H**, HIM program coordinator at **Clarkson College** in Omaha, Neb.

"Because payers following CPT guidelines do not consider postoperative infections as necessarily 'related' to the initial

surgery, you can charge for an E/M service. However, you should use the -24 modifier to tell the payer that the E/M service is distinct and not a part of the global surgical package," Bucknam says.

The Following 3 Examples Show You What To Do

Take a look at the following scenarios to help guide your postsurgical infection billing:

Coding example A: Several days following hernia repair (for example, 49560, Repair initial incisional or ventral hernia; reducible) the patient develops an infection at the site of the incision. The patient visits the surgeon at her office. The surgeon inspects and cleans the wound, changes the patient's dressings and administers antibiotics. For a private payer following CPT guidelines, the surgeon may report an E/M service (such as 99213, Office or other outpatient visit for the evaluation and management of an established patient ...) with modifier -24 appended. The modifier indicates that the service is not included in the global fee for the initial surgery. For a Medicare payer, however, the office visit counts as a part of the global package, and you cannot file an additional claim.

Coding example B: Three weeks following surgery, the surgeon readmits the patient to the hospital for wound abscess but does not return the patient to the operating room. Once again in this case, you may not report a separate service for Medicare, even though the surgeon re-admitted the patient. CMS guidelines specify that when the surgeon readmits the patient within the global period of the original surgery for complications of the original surgery, you cannot charge for the readmission.

But for payers following CPT guidelines you may report an appropriate admission code (for example, 99221, Initial hospital care, per day, for the evaluation and management of a patient ...) with modifier -24 appended.

Coding example C: The patient from Example A has more severe infection, reaching deeper into the surgical wound. To treat the infection, the surgeon returns the patient to the OR for debridement (for example, 11000, Debridement of extensive eczematous or infected skin; up to 10% of body surface). In this case, you should report 11000-78 for both Medicare and private payers.

Don't forget the diagnosis: In all cases, you should link an appropriate diagnosis, such as 998.59 (Other postoperative infection), to any CPT codes you report.

Don't Expect Total Reimbursement With -78

When you're filing claims with modifier -78, don't expect to receive the full fee schedule reimbursement amount. Procedures billed with modifier -78 include only the "intraoperative" portion of the service (no payment is made for pre- and postoperative care), Sandham says, and are generally reimbursed at 65-80 percent of the full fee schedule value, depending on the payer. But when you append modifier -78, you do not incur a "new" global period.