# Part B Insider (Multispecialty) Coding Alert

## Part B Coding Coach: Bust 3 Myths About How Global Rules Affect Your Postop Coding

**CMS and CPT disagree about one key term.**

If you automatically assume you can't separately report a surgeon's treatment of postoperative complications, you could be leaving money on the table. Knowing what qualifies as "typical" care will make your job easier.

Myth #1: All Payers Treat Postop Claims the Same

How you deal with postoperative complications depends on the payer you're dealing with, experts say. Medicare carriers treat postoperative complications differently than insurers that follow CPT guidelines. Although both CMS and CPT guidelines indicate that the global surgical package includes "typical" postsurgical care, the two groups vary on their definition of typical -- and that means you need to think differently based on the payer.

According to Medicare, all postoperative E/M services, including for complications, are included unless they are completely unrelated or meet an exception.

For procedures, a complication must be significant enough to warrant a return to the operating room or you cannot report a separate procedure. The "Correct Coding" guidelines from CMS 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.

**The difference:** CPT guidelines are less strict and say that you may report some postoperative E/M services the surgeon provides during the global period if they exceed typical follow-up care, even without a return to the OR.

Myth #2: You Don't Need a Modifier for Postop Services

When you report postoperative services to payers that follow CPT guidelines, you'll need to append modifier 24 (Unrelated evaluation and management service by the same physician during a postoperative period) to the CPT code to indicate that the service took place during the surgery's global period.

**Note:** "Modifier 24 is indicated for use of an evaluation and management code during the postoperative period; therefore, only E/M codes should be used with this modifier," says **Annette Grady, CPC, CPC-H, CPC-P, CCS-P,** compliance auditor at The Coding Network, and executive officer on the AAPC's National Advisory Board.

To gain reimbursement from private payers for unrelated postoperative evaluations during the global period, you should append modifier 24 to the appropriate E/M service code, says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-OBGYN, CPC-CARDIO,** manager of compliance education for the University of Washington Physicians (UWP) and Children's University Medical Group (CUMG) Compliance Program.

**Example:** If a patient returns to your office with a postoperative infection, such as a patient who has recently undergone parietal craniotomy for brain tumor excision (such as 61510, Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except menengioma) with advanced signs of infection along the suture line, you may be able to collect an additional $80 from private payers for a level-four established patient visit (99214) for the office visit and the neurosurgeon's treatment of the infection.

**CMS and CPT agree:** If the physician must return to the OR to deal with postop complications, both Medicare and private payers will pay at a reduced rate when you append the appropriate modifier to the CPT code to describe the surgeon's treatment of the postsurgical complication. If the surgeon is returning to the operating room for a related procedure during the global period of a previous surgery, the correct modifier is 78 (Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period).

You are paid at the full rate for unrelated procedures when you use modifier 79 (Unrelated procedure or service by the same physician during the postoperative period).

Myth #3: CMS and CPT Agree About "Related"

The difference between CMS and CPT is in their definitions of "related." CMS generally considers any subsequent procedures that occur in the same area to be related, even if done for a different diagnosis or for postop complications. "CPT, while less clear about the use of the terms, seems to allow treatment of different conditions to be considered 'unrelated' when they represent the onset of a new problem requiring a new evaluation (such as postop infection)."

A "related" procedure would be one that is an extension of the original surgery (such as revising the location of an intrathecal catheter).

**Best practice:** If your physician returns the patient to the OR for postoperative complications such as treatment of a postoperative infection, report the procedure for Medicare with modifier 78, and consider whether it may warrant modifier 79 for non-Medicare payers that adhere to CPT.

If the physician treats the infection in his office, however, you may only file a claim for those payers that follow CPT guidelines by using modifier 24 with the E/M service.