Part B Insider (Multispecialty) Coding Alert

PART B MYTH BUSTER: The End Of Surgery Doesn't Have To Be The End Of Your Reimbursement

The world doesn't always revolve around the global period

Myth: You can't bill for post-operative complications during a global period, unless the patient returns to the operating room (OR).

Reality: Medicare won't pay for post-op complications outside of the OR. But the **American Medical Association-s** CPT coding rules say the global period should only include -uncomplicated care,- says **Barbara Cobuzzi**, president of **CRN Healthcare Solutions** in Tinton Falls, NJ. And many non-Medicare payors will reimburse these complications in any setting.

-This is one of many cases in which CPT and reimbursement rules -bump heads,-- says **Jean Acevedo** with **Acevedo Consulting** in Delray Beach, FL.

The -Surgery Guidelines- section of the 2007 CPT book says you should separately report complications, exacerbations or recurrences, under the title -Follow-Up Care For Therapeutic Surgical Procedures.-

So if a patient has a post-operative infection or seroma, and your physician has to do a bedside incision and drainage (I&D), you could bill non-Medicare payors separately. You could even bill for a related evaluation & management visit, Cobuzzi says. You could use an ICD-9 code such as post-op seroma (998.13) or dehiscence (998.32) or destruction of an operation wound (998.31).

If your physician admits a patient for IV antibiotics to treat a post-operative infection, you can't bill Medicare. But you can bill private payors for the hospital care and subsequent hospital rounds with a 24 modifier (Unrelated E/M by the same physician). You must use the post-op infection diagnosis code (998.59), not the surgical diagnosis, Cobuzzi stresses.

Example: A patient with lupus is in the global period of a cesarian section. She arrives at the physician's office with dehiscence in her operative wound and the physician does an E/M visit and determines the wound must be drained. So you would use 998.32 as the diagnosis code, and bill 10180 for the I&D, appending the 79 modifier (Unrelated procedure or service by the same physician during the postoperative period). For the E/M visit, you-d append both the 24 and 25 modifiers because it's unrelated to the global period and significant and separately reportable from the I&D.

Note: Using the 79 modifier starts a new global period. By contrast, if you use the 78 modifier (Return to the OR for related procedure) it doesn't launch a new global period, Acevedo says.

They brought it on themselves

If a patient -causes- a complication, then it's usually easy to receive payment from private payors for extra services during the global period, says **Rena Hall**, coder and auditor with **KC Neurosurgery Group** in Kansas City, MO. For example, -a patient picked at her incision, causing a nice infection,- Hall recounts. -We saw her almost weekly because of it.- Another patient kept removing the pins from his -halo,- and it needed revision several times before the surgeon finally gave him a hard collar.

Hall keeps the documentation for these unusual circumstances at the ready, and sends it in whenever she receives a denial for the extra services. She-ll send the documentation with a letter of explanation.

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Important: Make sure your contracts with private payors spell out which billing rules you-ll follow: Medicare-s, or the AMA-s, Acevedo cautions. Medicare managed care plans typically follow Medicare's rules. But if your payor has nothing in writing that mandates Medicare rules, you should definitely try billing for services that CPT allows during a global period.

Bottom line: -Just assuming that -Everyone follows Medicare's rules,- can result in lost revenue,- Acevedo stresses.

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