Part B Insider (Multispecialty) Coding Alert

READER QUESTION: Know When You Can Report Visits After Global

You may have to explain why additional postop visits are required.

Question: Codes 10060 and 10061 have a 10-day global fee. If the patient, however, continues to have follow-up visits outside the global period, would it be appropriate to report the E/M level that is supported for the services received?

Example: We report 10061 on 6/15/09 -- so any related visits billed through 6/25/09 would be considered global. Patient then has additional follow-up visits on: 6/26, 6/30, 7/3, 7/7, 7/10, and 7/14. What is the best way (if any) to bill for the six follow-up visits provided outside the global period? Does modifier 24 apply?

Answer: Technically, you should code each of the medically necessary office visits (99212- 99215) that the doctor provides outside the 10-day global fee with no modifier.

You'll need modifier 24 (Unrelated evaluation and management service by the same physician during a postoperative period) only in a global period for a visit that is separate and distinct from the expected postprocedural follow-up.

Payment for the global period per Medicare is based on the number of follow-up visits typically performed for the procedure, such as 10060 (Incision and drainage of abscess [e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia]; simple or single). If more of these are required, and performed, you can separately report them.

Be prepared for the insurer to question why so many additional post-I&D visits are necessary. Make sure that the ICD-9 coding reflects any complications, such as infection (for instance, 682.5, cellulitis on buttock; or 250.xx, diabetes), that explain the unusual volume of follow-up visits.

Caution: Before billing the first technically non-included E/M service on 6/26, make sure that extenuating circumstances did not push the normally included related visit into a billable period. For instance, was the 25th a Sunday and you didn't have any office hours until the 26th? Or did your office have no visits available on the 25th or before, so the patient was forced to come in after the global period ended? Always double-check these possibilities before you submit your claim.