Codify
BY AAPC

Outpatient Facility Coding Alert

Reimbursement: Know Your Patients' Payers to Capture Legitimate Post-Op Revenue

Don't automatically skip billing for post-surgical infection care.

Wondering whether services associated with a postoperative complication are included with the original procedure or can be coded separately? If so, two simple tips will help you determine when you should bill for post-op care.

Tip 1: Divide Your Medicare and Non-Medicare Patients

Medicare treats postoperative complications (such as infections) differently than insurers who follow CPT® guidelines. Although both CMS and CPT® guidelines indicate that the global surgical package includes "typical" postsurgical care, they have different stances on what constitutes "typical" -- which means you must differentiate claims depending on which payer you're coding for.

CMS rule: Medicare requires that a complication be significant enough to warrant a return to the operating room before you may report a separate procedure in the global period. In fact, 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.

AMA rule: AMA is very clear on complications in the post-operative period. CPT® states in the front of the Surgical section, "Complications, exacerbations, recurrences, or the presence of other diseases or injuries requiring additional services should be separately reported." The same guideline applies whether you're evaluating follow-up care for surgical or diagnostic procedures.

Some non-Medicare payers may follow AMA CPT® guidelines and allow you to report services for treating postoperative complications that CMS typically bundles into the global period, including infection treatment that the surgeon provides in the office, says **Carol Pohlig, BSN, RN, CPC, ACS,** senior coding and education specialist at the University of Pennsylvania Department of Medicine in Philadelphia.

The bottom line: If treatment of a postoperative infection requires the provider to return the patient to the operating room, you should report the procedure to either Medicare or private payers.

Private payers do not have clear-cut rules, Pohlig notes. In fact, many of their coding guidelines are contractual. "What may be negotiated for one physician group may not be included in another group's contract," she says. "You should query the payers in writing beforehand to ensure proper coding and billing compliance."

Tip 2: Decide on the Best Modifier Usage

You'll need to add a modifier to the appropriate CPT® code to describe the physician's postsurgical infection treatment when filing with Medicare or with private payers that recognize modifiers.

If the surgeon returns 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). 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. You should use modifier 78 to indicate a return to the operating room for both private and Medicare payers.

Take note: Don't expect to collect the full fee schedule reimbursement amount when you file claims with modifier 78.

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Procedures billed with modifier 78 include only the "intraoperative" portion of the service (no payment is made for pre- and postoperative care), and insurers generally reimburse them 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.

2 Examples Guide How to Handle the Situation

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

Coding example 1: Several days following a tonsillectomy (for example, 42826, Tonsillectomy, primary or secondary; age 12 or over) the patient develops an abscess (ICD-9-CM 475) at the site of the incision. The patient visits the surgeon at her office. The physician prescribes antibiotics. The antibiotics don't cure the infection, so the surgeon readmits the patient a week following surgery. He prescribes IV antibiotics but does not return the patient to the operating room. CMS guidelines specify that when the physician readmits the patient within the original surgery's global period for complications of the original surgery, you cannot bill or charge for the readmission. Therefore, you shouldn't file an additional claim because Medicare considers the follow-up as part of the global package.

But for payers not following CMS guidelines, and following the AMA CPT® guidelines, you may be able to report an appropriate admission code (for example, 99221, Initial hospital care, per day, for the evaluation and management of a patient ...) with modifier 24 (Unrelated evaluation and management service by the same physician during a postoperative period) appended, Pohlig says.

Coding example 2: The patient's abscess requires an incision and drainage in the OR (for example, 42700, Incision and drainage abscess; peritonsillar). In this case, you should report 42700-78 for both Medicare and private payers. Don't forget the diagnosis to consider is 998.59 (Other postoperative infection), to any CPT® codes you report.

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