Outpatient Facility Coding Alert

You Be the Coder: Include Non-OR Complication Treatment in Global Surgery Payment

Question: We have a patient present to our office for an infected incision site 10 days following a total knee arthroplasty (27447). The provider examined the infection site and prescribed antibiotics. Are we allowed to bill this out as a complication of the initial procedure?

Michigan Subscriber

Answer: According to Medicare's Global Surgery Booklet, there are numerous services which a coder should consider an inclusive component of the global surgery payment. Of these inclusive components, the following guideline pertains to the question at hand:

- "All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room."

Since the patient did not return to the operating room (OR) for the surgical complication, you have to include the consultation service as a part of the initial global surgery payment. This applies whether the same physician, or a different physician within the group, performs the follow-up consultation.

Remember: If a patient does receive surgical care for a complication within the global period, make sure you have a firm understanding of what constitutes an OR visit. In the Global Surgery Booklet, Medicare defines an OR as "a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR)."

Since the patient received treatment within the 90-day global period for 27447 (Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing [total knee arthroplasty]), you will not bill out a separate professional charge for this service. However, if the evaluation and management (E/M) service occurs in a hospital-based outpatient clinic, HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) may be appropriate for the follow-up encounter.