

Coding issues related to the global surgery period

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This column lists some frequently asked questions regarding Current Procedural Terminology (CPT)* recently posed to the ACS Coding Hotline and the respective responses. ACS members and their staff may consult the hotline without charge as a benefit of membership in the organization. (For details, go to <http://www.facs.org/ahp/coding/secoding.html>.) Members and their coding staff may contact the ACS Coding Hotline at 800/227-7911 between 8:00 am and 6:00 pm Mountain Time, holidays excluded.

Several days after hernia repair (49560), a patient developed an infection at the site of the incision. When the patient came into the office, the surgeon inspected and cleaned the wound, changed the patient's dressings, and administered antibiotics. Can we bill for this visit?

Because the surgeon was able to treat the postoperative complication without returning to the operating room (OR), the visit and treatment are included in the global surgical package of the hernia repair and are not separately reportable.

A patient developed an infection several days after a hernia repair (49560). The infection was severe, reaching deep into the surgical wound. The surgeon sent the patient back to the OR for debridement. How should the debridement be coded during the global period for the hernia repair?

Use the debridement codes, such as 11000, *Debridement of extensive eczematous or infected skin; up to 10% of body surface*, with the modifier -78, *Unplanned return to the operating*

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Around the corner

For dates and locations of the 2009 ACS-sponsored Coding Workshop schedule, visit <http://www.facs.org/ahp/workshops/index.html>.

The College has once again contracted with Econo-mix to present a series of practice management webcasts. To register, go to <http://www.facs.org/ahp/workshops/teleconferences.html>.

- March 18: ICD-9 Diagnosis Coding for Physicians and Surgeons
- April 1: Appealing Third-Party Insurance Claims
- April 22: Effective Governance & Management of Your Practice
- May 6: Benchmarking Practice Productivity and Profitability
- May 20: Developing a Practical Compliance Plan

procedure room by the same physician following initial procedure for a related procedure during the postoperative period.

It is important to note that, according to the National Correct Coding Initiative (NCCI) manual,

Treatment of complications of primary surgical procedures is separately reportable with some limitations. The global surgical package for an operative procedure includes all intraoperative services that are normally a usual and necessary part of the procedure. Additionally, the global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require return to the operating room. Thus, treatment of a complication of a primary surgical procedure is not separately reportable (1) if it represents usual and necessary care in the operat-

ing room during the procedure or (2) if it occurs postoperatively and does not require return to the operating room.

The surgeon performed a hip replacement on a patient, who later, during the postoperative period, came to the office for a sprained wrist caused by a fall. Treatment for the wrist was performed in the office. Can we bill separately for this?

Yes, this office visit can be billed separately. Use modifier -24, *Unrelated evaluation and management service by the same physician during a postoperative period*, when, during the period of follow-up care for one surgical service, the surgeon provides an evaluation and management (E/M) service unrelated to the original condition.

A new patient visited the office for a consultation for abdominal pain. The surgeon determined that the patient needed immediate surgical care and scheduled the operation for later that same day. Is the initial visit separately reportable, or is it considered part of the global period for the surgery?

An E/M service that resulted in the initial decision to perform an operation may be identified by adding modifier -57, *Decision for surgery*, to the appropriate level of E/M service.

The NCCI manual offers the following guidance: “If an E/M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E/M service is separately reportable with modifier -57. Other E/M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable.” The global period for a major procedure is 90 days.

The manual also states that, “If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service.”

Resources

- *National Correct Coding Initiative [NCCI] Policy Manual for Medicare Services*, Centers for Medicare & Medicaid Services
- *Principles of CPT Coding*, 5th ed, American Medical Association
- *Specialty Study Guide: General Surgery*, 2008, American Academy of Professional Coders

A new patient who had recently had surgery with a physician in another state visited the office for postoperative care only. Do we bill each visit for postoperative care because our physician did not perform the operation?

The physician who performs the postoperative management reports the operative procedure code with the modifier -55, *Postoperative management only*.

Where can I go for additional information?

For help with coding and bundling issues, go to <http://acs.codingtoday.com/> for a free 30-day trial of Coding Today, sponsored by the ACS. 