

# Socioeconomic tips of the month

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Q.

How do we code for observation?

A.

You will need to verify the patient status with the hospital to ensure the use of the correct status code. When the patient is admitted and discharged on the same date to observation status you will use evaluation and management (E/M) codes 99234-99236 (observation or inpatient care services including admission and discharge services), depending on the level of care provided. If the patient is admitted to the hospital from the observation status on the same date as the admission to observation, bill only the initial hospital care (and any subsequent care if the hospitalization extends beyond one day), depending on the level of care provided. If the patient is admitted for observation and then is admitted as a hospital inpatient on the following day, the physician will bill the appropriate initial observation care code (99218-99220) for the day spent in observation, and the appropriate initial hospital care (99221-99223) for the day of hospital admission. If the patient is discharged from observation on a day other than the initial date of observation, the observation care discharge code 99217 may be reported. Use 99217 in addition to 99218-99220 only; do not report 99217 in addition to 99234-99236, since these codes include admission and discharge. The observation care should not be reported separately when it falls within a global period of a procedure.

Q.

If the patient is still within the global period and comes back to the office for postoperative care, can we charge for the visit?

A.

The first thing to do is to check if the global period is 0, 10, or 90 days. For patients returning for postoperative care from a 0-day global procedure, such as a skin biopsy, CPT 11000 (postoperative care) is reported with an appropriate level of E/M for an established patient (CPT 99211-99215) depend-

ing on the level of service, usually CPT 99212 or 99213. For drainage of an abscess, if additional postoperative care is required for this 10-day global procedure on day 11, an appropriately documented E/M visit may be billed. Normal postoperative care is *included* in the surgical procedure reimbursement, and is not to be reported separately. However, if the patient is being seen within the 10- or 90-day global period for an *unrelated service*, report the E/M visit and append modifier -24 (Unrelated E/M service by the same physician during a postoperative period).

Q.

When my doctor does a biopsy on a patient, and the biopsy comes back positive for cancer, we generally bring the patient back to the office a few days later for counseling and to discuss treatment options. How do we bill for the consultation and the surgery that may occur?

A.

Check the length of the global period for the biopsy procedure. For those situations in which the biopsy has a 0-day global period or you are beyond the 10- or 90-day global period, the E/M services and subsequent surgical procedure can be billed independent of the biopsy. In the situation described, where the follow-up E/M service and surgery are performed within the global period of the biopsy, the services are at risk of denial. Modifiers have been developed to assist physicians to accurately code the service performed and to pull certain services out of the global period when appropriate. Note that modifiers are listed in Appendix A of *CPT 2000*. In your situation, the office visit is being used to counsel the patient on treatment options and expectations, not as an evaluation of the postoperative site. Therefore, it is appropriate to append modifier -24 to the E/M visit, and report with a diagnosis code of cancer. In situations where the need for a more extensive operation is identified by the lesser procedure (the biopsy reveals the need for radical surgery), and where a more extensive surgery was planned prospectively at the time of the original procedure, the use of modifier -58 would be appropriate. In the case of the planned procedure, the patient's medical record must reflect the need

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for the second operation. For example, the patient comes into the surgeon's office for the evaluation of a suspicious lump. The surgeon and patient decide on the need for a surgical biopsy, with a discussion of the treatment options later after the pathology report is available. Modifier -58 (Staged or related procedure or service by the same physician during the postoperative period) is appended to the procedure at risk of denial, the more extensive procedure in this case. For the planned procedure, it is not necessary to report a different condition or diagnosis code being treated.


**Q.** The physician sees a patient who is within a 90-day global period and determines the patient requires a trip to the operating room for a different procedure (one with a 10-day global). The patient also requires extensive follow-up visits that do not fall into the norm. How do we code for the care provided to the patient?

**A.** If the second procedure is *unrelated* to the first procedure, you should append modifier -79 (Unrelated procedure to service by the same physician during the postoperative period) to the second procedure. Because the global period for the second procedure is less than the global for the first procedure, the global periods will run concurrently until the 10-day period expires leaving only the 90-day global period in effect. Any E/M care that is *unrelated* to either of the surgeries should be reported with modifier -24 (Unrelated E/M service by the same physician during a postoperative period).

**Q.** Can we charge for both the ultrasound and the office visit when performed during the same visit?

**A.** When the patient is *scheduled* for the ultrasound, generally an office service is not separately billable even though the ultrasound does not have a global period assigned. The reimbursement assigned to the ultrasound includes the office space and equipment expense, therefore, unless a separate office service is rendered and fully documented; it

is not appropriate to bill separately for the office visit. However, if during the ultrasound exam it is determined that the patient *requires* an E/M service and an *E/M service is provided and documented in the medical record*, it is appropriate to report the two services separately, appending modifier -25 to the E/M code. In the situation where during an E/M service it is determined that the patient *requires* an ultrasound, again, report the services separately, appending modifier -25 to the E/M code.

Reminder: Purchase ICD-9-CM and *CPT 2001* books. 

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This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Chicago staff of the Health Policy and Advocacy Department, tel. 312/202-5150; fax 312/202-5021; or e-mail [HealthPolicyAdvocacy@facs.org](mailto:HealthPolicyAdvocacy@facs.org).