

American Academy of Professional Coders

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May 2010

CMS vs. CPT®

LuAnn Jenkins,
CPMA, CPC, CEMC, CFPC
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Plus: SNF and NF • Whistleblower • Third-party Billing • Mentoring • 50, LT, RT • 90-99



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On the Cover: LuAnn Jenkins, CPMA, CPC, CEMC, CFPC, president/owner of MedTrust LLC in Lapeer, Mich. knows deciding between CMS and CPT® guidance isn't as easy as choosing a soft drink, especially when there is conflicting global guidance on postoperative services. Cover photo by Rick DeLorme, MA, MS (www.delormephoto.com).



CMS vs. CPT®

What Can You Bill Postoperative?

Surgical complication billing gets tricky when global surgery guidance conflicts.

By LuAnn Jenkins, CPMA, CPC, CEMC, CFPC

In 1992, the “global surgery” concept was introduced under the Resource Based Relative Value Unit System (RBRVS) and payment policy. Medicare adopted this method to control costs and to pay providers based on the value of services provided before, during, and after surgical procedures. Many commercial payers also adopted this system as the basis for their fee schedules and global periods; however, not all payers follow all of Medicare’s global surgery payment policies. The CPT® manual provides guidance on coding and also defines what a “global surgery” includes from a coding perspective.

This can be very important for surgical complication billing because CPT® policy is less restrictive than Medicare.

Know Your Payer, Know the Rules

Accurate coding and billing requires knowing your payer rules prior to claims submission. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) named CPT® and HCPCS Level II as the national code sets and required all entities to be able to accept those codes. It did not, however, require payers to pay all codes or adopt uniform CPT® coding policies.

Do not assume all payers follow all of Medicare’s policies; payers may choose to use all or part of the Medicare global fee rules. They may use the global days and relative value units (RVUs), but not the national Correct Coding Initiative (CCI) or other specific rules. For example, Michigan’s Workers’ Compensation Agency uses the RBRVS system as a basis for their fee schedule and global days, but follows the CPT® post operative complication rule.

Postoperative complications may consume significant time and resources. If the services legitimately can be billed, be sure to capture that revenue. Gathering policy information can be time consuming, but provide a valuable tool to share with coders and billers. Adopting a “one size fits all” coding/billing policy may be easier in the short term, but can be costly and result in lost revenue for your practice.

In the end, it is your contracts that dictate the coding and billing rules you must follow. What you can bill to an insurance company depends on the payer involved.

In the end, it is your contracts that dictate the coding and billing rules you must follow. What you can bill to an insurance company depends on the payer involved. As a result, what you bill for a particular service may vary from one patient to another. Postoperative complications that never would be billed to Medicare, for example, may be allowable under a commercial payer contract.

Gather information pertaining to your specific type of practice. Issues such as complication rules, global days, and modifier definitions are crucial to each practice and vary by payer. In medical billing, too often we learn by trial and error; we bill a service, receive a denial or partial payment, and then contact the payer and discover what created the problem. Often, an unknown or misunderstood payer rule is to blame. Unfortunately, this information isn't always documented or shared, and the same (wrong) steps are repeated.

If you are unable to get specific answers in payer manuals, contact medical directors in writing to ask what the medical policy is on postoperative complications.

Create a resource for your office. Following documented guidelines will enable you to confidently submit clean claims to all payers, which will result in lower denial rates and fuller reimbursement for services provided.

Applying Modifiers for Postoperative Reimbursement

Modifiers are the key to payment for surgical complications. Both CPT® and Medicare agree that a complication requiring a return to the operating room (OR) should be paid separately using the appropriate modifier. Complications requiring treatment outside of the OR that are provided in the office, outpatient, or inpatient setting also will require modifiers for those non-Medicare payers that follow CPT® guidelines.

Complications requiring additional surgical procedures in the OR related to the original surgery require modifier 78 *Unplanned return to the operating room/procedure room by the same physician following initial procedure for a related procedure during the postoperative period* to be appended to

the appropriate procedure code. Under the Centers for Medicare & Medicaid Services (CMS) policy for this purpose, an OR is defined 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).”

For example, a patient undergoes carotid endarterectomy (35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision*), performed in the morning. Later that day, the patient is returned to the OR for exploration of the neck for postoperative hemorrhage. The return to the OR is coded as 35800 *Exploration for postoperative hemorrhage, thrombosis or infection; neck*, with modifier 78 appended.

Note: In certain circumstances, a return to the OR during the global period may call for modifier 58 *Staged or related procedure or service by the same physician during the postoperative period* rather than modifier 78. *Medicare Claims Processing Manual*, chapter 12, section 40.1.B states “If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.” In such a case, modifier 58 is appropriate.

For example, a patient is seen and treated with closed reduction of a tibial shaft fracture (27750 *Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation*). One week later, it is determined the closed reduction failed, and the patient is taken to the OR for an open treatment. Coding for the more extensive procedure is 27758 *Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage*, with modifier 58 appended.

Unrelated post-operative evaluation and management (E/M) services are reported with modifier 24 *Unrelated evaluation and management service by the same physician*

Postoperative complications that never would be billed to Medicare, for example, may be allowable under a commercial payer contract.

during a *postoperative period* appended. Beware: CMS' Office of the Inspector General (OIG) has added modifier 24 to its annual Work Plan due to concern of misuse and resulting overpayments. The appropriate use of modifier 24 depends on what rules your payer follows.

Under Medicare policy, modifier 24 applies for:

- Visit for a new problem unrelated to surgery—supported by different ICD-9-CM code
- Visit for treatment of the underlying condition (**not** wound care, pain management, or a repeat procedure)

Under CPT® guidelines, modifier 24 applies for:

- Visit for a new problem unrelated to surgery—supported by different ICD-9-CM code
- Visit for treatment of the underlying condition, *and*
- Visit for treatment of complications, exacerbations, recurrence

For example, a Medicare patient is returning for a 30-day follow-up visit for a hip replacement. At the visit, the patient complains of new onset shoulder pain, which is evaluated and treated. Because the new complaint is unrelated to the previous surgery, you may separately report the E/M service using an established patient office visit code (9921x) with modifier 24 appended. The visit should be linked to a new diagnosis of 719.41 *Pain in joint; shoulder region*. A surgical procedure at the same visit—for example, a joint injection 20610 *Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)*—requires you to append modifier 79 *Unrelated procedure*.

In a different example, a patient with third-party insurance returns for a 10-day follow-up visit to hip replacement surgery complaining of a painful incision and fever. The excision is not healing and shows redness and drainage. The physician assesses the wound and treats the patient for postoperative wound infection. Assuming the payer follows CPT® guidelines, this visit is separately billable as 9921x-24, at the service level supported by documentation. For Medicare payers, however, the visit is not separately billable; the postoperative wound infection is “related” to the original surgery and did not require a return to the operating room. The service is bundled into the global surgical package for Medicare payment.

An example of treating the underlying problem is a breast biopsy (19101 *Biopsy of breast: open incisional*). If the result of the biopsy is a malignant neoplasm, and the patient is seen within the global period (10 days) to discuss treatment of a malignancy, the E/M service is reported with modifier 24 to indicate treatment of the underlying condition. If major surgery is performed within this 10-day period, modifier 58 would be applied to the service as a more extensive procedure. ■



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Define the Global Surgery Package

As outlined in the *Medicare Claims Processing Manual*, Pub. 100-4, chapter 12, section 40.1, CMS includes the following items/services in the global surgical package:

- Preoperative visits after the decision is made to operate, beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- Complications following surgery, including all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
- Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- Postsurgical pain management by the surgeon;
- Supplies (except for those identified as exclusions); and
- Miscellaneous services/items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheotomy tubes.

In contrast, CPT®, as detailed in the Surgery Section Guidelines, defines the global surgical package to include:

- Local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia;
- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical);
- Immediate postoperative care, including dictating operative notes, walking with the family and other physicians;
- Writing orders;
- Evaluating the patient in the post-anesthesia recovery area;
- Typical postoperative follow-up care.

CMS and CPT® also *exclude* different services from the global surgical package. Per Medicare, the following items/services are NOT included in the global surgical package:

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Please note that this policy only applies to major surgical procedures. The initial evaluation is always included in the allowance for a minor surgical procedure;
- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ambulatory surgery center (ASC) record;

- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;
- Diagnostic tests and procedures, including diagnostic radiological procedures;
- Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy (such as craniotomy procedures 61533, 61534-61536, 61539, 61541, and 61543), which may be performed in succession within 90 days of each other;
- Treatment for postoperative complications that require a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the *sole purpose of performing procedures*. An OR may include 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 is insufficient time to transport to an OR);
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;
- For certain services performed in a physician's office, separate payment no longer can be made for a surgical tray (code A4550). Splints and casting supplies are payable separately under the reasonable charge payment methodology;
- Immunosuppressive therapy for organ transplants; and
- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously-injured or burned patient is critically ill and requires constant physician attendance.

Under CPT® rules, the following services are NOT included in the global surgical package:

- Follow-up care for diagnostic procedures (eg, endoscopy, arthroscopy, injection procedures for radiography) includes only care related to the recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.
- Follow-up care for therapeutic surgical procedures includes only care which is usually a part of the surgical service. Report complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services separately.