CODING Q&A

Follow-up Questions Regarding Post-operative Care and 'Established' Patients

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Q. I was curious about your response to a case listed in Coding Q&A in the November issue of *JUCM*. The case described a patient who returned for re-opening of a wound due to infection. The physician then cleansed and re-sutured the wound.

Although I agree about the postoperative care in general, I wonder if modifier -79 would be appropriate in these circumstances.

According to instructions by the AMA, this modifier may be used for circumstances when the service is not related to the original service. The infection of the wound is not part of regular global package services. If they had used the diagnosis of wound infection (a different diagnosis from the original service) along with the appropriate CPT, I wonder if this would have resulted in payment.
- Questions submitted by Elaine D. Wade, BSN, CCS-P, Presbyterian Health Services

A. What you describe may be a compliant method for obtaining payment for payors not governed by Centers for Medicare and Medicaid Services (CMS) rules.

Unless the payor has specified otherwise, you can follow the AMA rules for coding of global services. The AMA guidelines state that only routine follow-up care is included in the global period, so many payors may allow you to bill for additional procedures related to complications that occurred during the global period.

In the specified case, the payor was Medicare so all follow-up care (including, "complications following surgery, which do not require additional trips to the operating room") is included in the global period.

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If the patient was actually taken back to a true "operating room" for a procedure, then one would use modifier -78 (Return to the operating room for a related procedure during the postoperative period) to the procedure code. A "minor treatment room" (i.e., a typical procedure room in an urgent care center) does not qualify as an operating room. CMS makes this point in its definition of an "operating room" in the context of a global period (see *www.cms.hhs.gov/manuals/downloads/clm104c12.pdf*):

> *An "operating room" is defined as a place of service specifically equipped and staffed for the sole purpose of performing surgical procedures. The term included 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 operating room.*

What about the use of modifier -79 (Unrelated procedure of service by the same physician during the postoperative period)? Yes, it may aid in receiving payment, and private payors may allow you to use this modifier in this way.

However, for CMS payors, modifier -79 is only for procedures that are completely unrelated to the original procedure. Procedures that are for treatment of complications of the original procedure are not truly "unrelated" to the original procedure, so modifier -79 does not apply to these procedures.

NOTE: The specific question that was addressed indicated that the wound was not re-sutured. It was simply opened and rechecked several times. No second procedure was performed.

Even so, under the AMA definition of the care included in the global period (but not under CMS rules for the global period), one could code an E/M for each recheck for the complication.

Your payor may allow you to use modifier -24 (Unre-

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lated E/M service by the same physician during a postoperative period) in this situation, but in the case of Medicare this would not be an appropriate use of modifier -24, as a wound infection is actually related to (i.e., a complication of) the original procedure. ■

Q. I recently attended the UCAOA Conference in Chicago. In one of your seminars, we discussed new vs. established patients.

Our facility uses physicians that have their own separate practices. It is my understanding that if a physician has seen a patient in his or her office and then that patient is treated here by that physician, then for coding purposes the patient is treated as an "established" patient.

Since we do not have access to the other records, how are we protected with such a limited exam? How do we support the documentation of an established visit when they are essentially a new patient?

One of our challenges is determining if and when they have been seen at the other practice. Since there is no relation between the two practices, we would have to depend on the physician's memory, the patient, or request records from the office.

- Questions submitted by Abbi Olson, Urgentcare/Corpcare

A. The provider should do whatever history/exam is indicated (whether the patient is new or established) and code accordingly. The fact that the patient is "established" does not mean the provider should do a limited exam. A full history and physical may be necessary.

You will need to make your "best reasonable" efforts to determine if the patient is new or established with any provider. The method that you describe may be the best approach that is actually feasible in real life.

It would be ideal to get a full database of the patients from the other practice where the provider works. That would give you a full proof method to check for established patients. Absent receiving an actual patient database, maybe you could ask the other practice to check each day's list of patients against the other practice's patient database. ■

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often more important than what they've done in the past. Ask applicants questions pertinent to their prospective position and to your circumstances.

- **Develop a written plan.** A patient service plan is as important as a marketing plan. However, practices with occupational health programs rarely have such a plan, assuming that their staff can manage things effectively.

  However, a plan defines an organized approach and instills a sense that your patient service ethic is more than lip service.
- **Involve everyone.** A patient service ethic should be instilled in everyone who comes into contact with a patient. This includes physicians, other care providers, receptionists and clerks, clinic or program directors, and sales and marketing personnel. Optimal patient service should be expected from all members of a clinic or program team.
- **Set the bar high. "**Patient satisfaction" can be misleading. The absence of documented dissatisfaction (i.e., complaints) may be misconstrued as your clinic having a high degree of patient satisfaction.

  In occupational health programs, "just OK" is not OK.

  Your clinic should go beyond patient *satisfaction* and strive for the highest possible degree of patient *loyalty*. Your program must upgrade from "standard" to "above reproach."
- **Conduct patient service training.** New employees should go through a 60-90 minute customer service training period during their first day or two on the job. All employees should undergo refresher training once a year. Common scenarios should be reviewed and role-playing should be encouraged.
- **Evaluate.** Frequent feedback at both the employer and patient level is likely to preempt patient service deficiencies before they become chronic, while also providing positive reinforcement of deeds well done.

  Try to quantify as much satisfaction data as possible (e.g., "Were you satisfied with our services?" should be rephrased as "On a scale of 1 to 5, how satisfied were you with our services?") in order to develop "report cards" and measure secular trends.
- **Reward.** Try to make patient service fun. Post a graph with changes in daily patient satisfaction scores in a prominent place. Provide a "patient service act of the month" award. Instill the ethic each and every day in a meaningful manner. ■