General Surgery Coding Alert

Reader questions: Capture Separate E/M in Post-Op Period

Question: Our surgeon performed a rubber band ligation to treat hemorrhoids. Three days later, the patient returned with vomiting and a fever. The doctor diagnosed infectious gastroenteritis (009.1). How do I code the return visit?

Texas Subscriber

Answer: You should code an appropriate E/M service from the range 99211-99215 (Office or other outpatient visit for the evaluation and management of an established patient,...), but you'll need a modifier, too.

Although the hemorrhoid ligation (46221, Hemorrhoidectomy, internal, by rubber band ligation[s]) has a 10-day global period, the return visit is unrelated to that procedure. That's why you should add modifier 24 (Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period) to the appropriate E/M code on your claim.

The documentation supporting the 99211-99215 service is information that relates to the vomiting and fever. If your surgeon also checked on the hemorrhoid removal, you can't count those services when you determine the E/M level.

The specific E/M code you claim depends on the level of service your doctor provides for the fever and vomiting, with supporting documentation for the history, examination, and medical decision making (MDM).

You should also include the infectious gastroenteritis ICD-9 diagnosis code 009.1 (Colitis enteritis and gastroenteritis of presumed infectious origin, [ICD-10: A09, Infectious gastroenteritis and colitis, unspecified]) on your claim.