Deal Breakers in General Surgery

Nancy Reading BS, CPC, CPC P, CPC I

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CORE VALUES

Elevate Medical Solutions has five core values: Integrity, Humility, Knowledgeable, Solutions Focused, and Team Player. Our focus from day one has been on our people. While everyone's walk of life is unique, we see a common theme in the professional journey of our people. Everyone on our team has a passion for what they do. They care about it, they get excited about it, and they love to watch their skills tackle the challenges their team is setting out to resolve.

Clarification

CODING ISSUES

VERSUS

REIMBURSEMENT ISSUES

Surgical Conventions

- Know the coding rules
- Know the Billing Rules
- Become proficient in Modifier use
- Understand Bundling
- Know where to find the correct surgical diagnosis
- Gain a working understanding of surgical anatomy
- Code Anything!

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Assigning the Correct ICD 10 CM Code

- Gold Standard - The post-operative diagnosis is the diagnosis to list first on the physician/surgeon's 1500 form when the surgery was the reason for care on that date of service.
  - The Post-Operative diagnosis should incorporate any intraoperative findings
  - If the Pre and Post operative diagnoses are the same, then it does not matter.
- Co-morbid conditions requiring care from the surgeon should also be listed
- Patients admitted for a reason other than surgery will require special consideration based on who is providing care for the diagnosis (es) in question.

Assigning the Correct ICD 10 CM Code

- Patients admitted to post-operative observation the post-operative surgical diagnosis is still listed first and the reason for observation is listed second.
- Remember admission to Observation would not be appropriate for patients who:
  - Are placed in observation for routine stays following late surgery;
  - Outpatient therapy/procedures (unless there is documentation that the patient's condition is unstable);
  - Normal postoperative recovery time following surgery;
  - Stays for the convenience of the patient, family, or doctor; and
  - Stays prior to an outpatient surgery procedure.

  - Rebooting "Observing the Rules for Observation After Outpatient Surgery" – RACmonitor

Diagnoses Warranting Observation

- Unrelenting nausea/vomiting;
- Fluid/electrolyte imbalance;
- Uncontrolled post operative pain;
- Arrythmias;
- Hemorrhage;
- Psychosis, altered behavior;
- Unstable level of consciousness; and
- Unstable mobility/coordination.

Global Surgical Package

- Pre Op Period
  - Subsequent to decision for surgery, 1 E/M service on date immediately prior to or day of surgery
- Intraoperative Period
  - Skin to Skin
- Post Operative Period
  - Major = 90 days
  - Minor = 10 days

RBRVS File April 2025

2025 National Physician Fee Schedule Relative Value File April Release

RELEASED 02/20/2025

HCPCS	DESCRIPTION	STATUS CODE	GLOB DAYS	PRE OP	INTRA OP	POST OP	MULT PROC	BILAT SURG	ASST SURG	CO-SURG	TEAM SURG
21920	Biopsy soft tissue of back	A	010	0.10	0.80	0.10	2	0	1	0	0
21925	Biopsy soft tissue of back	A	090	0.10	0.69	0.21	2	0	1	0	0
21930	Exc back les sc < 3 cm	A	090	0.10	0.69	0.21	2	0	1	0	0
21931	Exc back les sc 3 cm/>	A	090	0.10	0.69	0.21	2	0	2	0	0

Post Operative Days

- **000**=Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.
- **010**=Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable

Post Operative Days

- **090**=Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount.
- MMM=Maternity codes; usual global period does not apply.
- **XXX**=The global concept does not apply to the code.
- **YYY**=The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.
- **ZZZ**=The code is related to another service and is always included in the global period of the other service.

Percentages

- **Preoperative Percentage** - Percentage for preoperative portion of global package.
- **Intraoperative Percentage** - Percentage for intraoperative portion of global package, including postoperative work in the hospital.
- **Postoperative** - Percentage for postoperative portion of global package that is provided in the office after discharge from the hospital.

Global Surgical Package

- Local, Metacarpal /Metatarsal/Digital Block or topical anesthesia
- Writing orders
- Evaluation of patient in post anesthesia recovery area

Global Surgical Package

- Immediate Postoperative Care,
  - Including dictating operative notes
  - Talking with family
  - Talking with other physicians
- Typical **uncomplicated** post operative care

Global Surgical Package Modifiers

Pre-operative (≃10% $)	Intra-operative (≃60% $)	Post-operative (≃30% $)
1 E/M subsequent to Decision for Surgery	Skin to Skin Local infiltration	Follow-up days or FUDS Major = 90 days
Modifier -57	Modifier -24	FUDS - Minor = 10 days
Modifier - 25	Modifier -54	Normal / Uncomplicated
Modifier - 56	Modifiers -22,-52, -53	Writing post op orders
	Modifier -59	Post anesthesia evaluation
	Modifier -62, -66	Modifier -55
	Modifier -63	Modifier -78 Vs -58
	Modifier -80, -81, -82	Modifier -76 Vs -77
	Modifier -50, -LT, -RT	
	Modifier -51	Modifier -79

Multiple Procedure Reduction

- Multiple surgeries or procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session, reduction in reimbursement for secondary and subsequent procedures may occur.

Multiple Procedure Reduction

- The primary (highest valued) procedure will be reimbursed at 100 percent of the fee schedule value, and the second and all subsequent procedures will be reimbursed at 50 percent of the fee schedule value for Medicare
- Private third-party payers may have each have their own stratification for reimbursement.

RBRVS MPR

- **0=No payment adjustment rules** for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.
- **1=Standard payment adjustment rules** in effect before January 1, 1995 for multiple procedures apply. In the 1995 file, this indicator only applies to codes with a status code of "D". If procedure is reported on the same day as another procedure that has an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 25%, 25%, 25%, and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage.

RBRVS MPR

- **2**=Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report).
  - Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage.

  - RVU25B.pdf

RBRVS MPR

- **3**=Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the Endobase field of this file. Apply the multiple endoscopy rules to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

RBRVS MPR

- **4**=Special rules for the technical component (TC) of diagnostic imaging procedures apply if procedure is billed with another diagnostic imaging procedure in the same family (per the diagnostic imaging family indicator, below). If procedure is reported in the same session on the same day as another procedure with the same family indicator, rank the procedures by fee schedule amount for the TC. Pay 100% for the highest priced procedure, and 50% for each subsequent procedure. Base the payment for subsequent procedures on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 through December 31, 2016). Subject to 5% reduction of the PC of diagnostic imaging (effective for services January 1, 2017 and after).

RBRVS MPR

- **5**=Subject to 50% of the practice expense component for certain therapy services.
- **6**=Subject to 25% reduction of the second highest and subsequent procedures to the TC of diagnostic cardiovascular services, effective for services January 1, 2013, and thereafter.
- **7**=Subject to 20% reduction of the second highest and subsequent procedures to the TC of diagnostic ophthalmology services, effective for services January 1, 2013, and thereafter.
- **9**=Concept does not apply.

Payer Preference and Modifier 51

- Claims Processing Manual section 40.6
  - Report the more major surgical procedure without the multiple procedures modifier “51.” •
  - Report additional surgical procedures performed by the surgeon on the same day with modifier “-51.” clm104c12.pdf
- MACS may say no modifier 51
  - “Do not append modifier 51 to the additional procedure code. The Medicare claim processing system has a hard coded logic to append it to the correct procedure code.”

51 - JE Part B - Noridian

Payer Preference and Modifier 51

- Private Payers dsnp-reimbursement-policy-modifiers-50-51.pdf
  (Blue Cross and Blue Shield NC)
  - "When multiple procedures, other than E/M services, physical medicine and rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending Modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated add-on codes."

Add - On Codes (+)

- Exempt from multiple surgical reduction
- Exempt from use of modifier -51
- Can not stand alone
- Take on the global postoperative period of the principal service (ZZZ in MFDS)

Add - On Codes (+)

- Identified by "each additional" or "list separately in addition to"
- Lower value is built in
- The "add-on" code concept in CPT applies only to add-on procedures/services performed by the same physician.

Modifier -51 Exempt ()

- Exempt from the use of modifier -51
- Have not been designated as CPT add-on procedures/services

Semi Colons

- CPT has Parent and Child Codes.
  - The *Parent Code* has the full description
  - Each *Child Code* has information for services that are additional to the parent code
- There is a semi-colon in the description of the parent code indicating the verbiage/description prior to the semi-colon is included in the parent code and carries down to the child code.

Semi Colons

- Example: Parent code is in blue
  - –11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first **20** sq cm or less
    - 11045 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Separate Procedures

- Commonly carried out as an integral component of a total service or procedure
- Identified by including the term "separate procedure" in ()
- Do not report in addition to the code for the total procedure or service for which it is considered an integral component.

Medicare on Separate Procedures

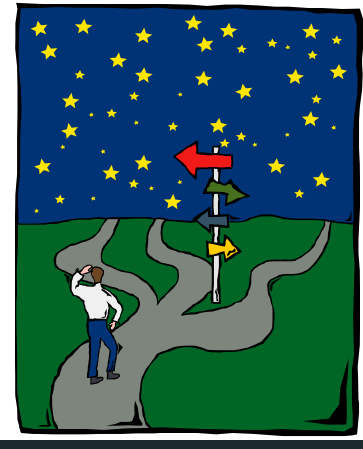
- "… the codes listed as ‘separate procedure’ should not be reported in addition to the code for the total procedure or service.
- The only time to report a separate procedure is, if it is not performed with a primary procedure that encompasses the ‘separate’ one, or when it adds ‘appreciably to the time and/or complexity of the procedure.’"

Modifiers

- Indicate that a procedure has been changed in some way
- Indicate special circumstances
- Tell the whole story
- Can affect the fee

Modifiers

- CPT - Located in Appendix A
- HCPCS – Located in either the front introduction or for some publications in the Appendix.



Steps to Generating a CMS 1500 Form

- List CPT codes from highest to lowest **RVU**
- Determine which codes can be billed
  - –NCCI (National Correct Coding Initiative)
  - –Separate Procedure
- Apply Modifiers
- Link ICD-10-CM codes to CPT codes
- Fill in the appropriate number of units

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NCCI

- Updated Quarterly by CMS
- Two types of edits
  - –Bundled Services
    - Column A will pay
    - Column B will deny w/o an over-ride modifier
    - Based on “Standard of Medical Practice”
  - –Mutually exclusive edits

Override Modifiers

- The presence of these modifiers override an NCCI edit
- Examples
  - Modifier 25
  - Modifier 59
  - Modifier 58
  - Modifier 78
  - Modifier 79
  - Modifier XS
  - Modifier 91

Override Modifiers

Anatomical Modifiers		
-E1	-F6	-T2
-E2	-F7	-T3
-E3	-F8	-T4
-E4	-F9	-T5
-FA	-LD	-T6
-F1	-RC	-T7
-F2	-LT	-T8
-F3	-RT	-T9
-F4	-TA	
-F5	-T1	

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OIG 2025 Hit List
Use of Modifier -25 Dermatology

- "The decision to perform a minor surgical procedure is included in the payment for a minor surgical procedure and must not be reported separately as an E/M service. An E/M service should be billed only on the same day if a surgeon performs a significant and separately identifiable E/M service that is unrelated to the decision to perform a minor surgical procedure."
- In 2019 an estimated 56% of Dermatology claims inappropriately appended modifier 25. Dermatologist Claims for Evaluation and Management Services on the Same Day as Minor Surgical Procedures

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OIG 2025 Hit List
Use of Modifiers With NCCI Edits

- Modifier 59
- Never add to E/M service
- Documentation must support
  - a different session,
  - different procedure or surgery,
  - different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries)
- Only use modifier 59 if there is not another more specific/appropriate modifier.

- mln1783722_proper_use_modifiers_59_xe_xp_xs_and_xu.pdf

NCCI Indicators

- NCCI code pairs, are assigned a modifier indicator. This indicator can be “0,” “1,” or “9.”
- **Indicator 0**: These codes should never be reported together by the same provider for the same beneficiary on the same date of service (DOS).
- **Indicator 1:** These codes may be reported together only in defined circumstances (identified on claims by specific NCCI-associated modifier).
- **Indicator 9**: Not relevant. The edit was deleted.

- If a code pair is marked **with indicator 0, you should never use modifier 59** to try and separate them.

OIG 2025 Hit List
Use of Modifiers With NCCI Edits

- CMS allows modifiers 59, XE, XP, XS, or XU on Column 1 or Column 2 codes
- XE — "Separate encounter, a service that is distinct because it occurred during a separate encounter." Only use XE to describe separate encounters on the same DOS.
- XP — "Separate practitioner, a service that is distinct because it was performed by a different practitioner."

- mln1783722_proper_use_modifiers_59_xe_xp_xs_and_xu.pdf

OIG 2025 Hit List
Use of Modifiers With NCCI Edits

- CMS allows modifiers 59, XE, XP, XS, or XU on Column 1 or Column 2 codes
- XS — "Separate structure, a service that is distinct because it was performed on a separate organ/structure."
- XU — "Unusual Non-Overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service."

- mln1783722_proper_use_modifiers_59_xe_xp_xs_and_xu.pdf

Claims Processing Snapshot

- Provider
- Patient
- DOS

Anatomy of the Operative Note

- Verify Patient Identification
  - Patient (Name, medical record id, hospital admission number, unit number….)
  - Dates (e.g. date of admission and/or date of surgery)
- Verify Provider Identification
  - Name(s)of attending, assistant, co-surgeons or team members
  - Names of students, residents and/or fellows.
  - Name of Anesthesiologist and/or CRNA.

Anatomy of the Operative Note

- **PREOPERATIVE DIAGNOSIS**:
  Penetrating gunshot wound to abdomen
- **POSTOPERATIVE DIAGNOSIS**:
  Gastric microperforation secondary to gunshot wound
- **OPERATION PERFORMED**:
  1. Exploratory laparotomy.
  2. Repair of gastric microperforation.

Anatomy of the Operative Note

Anatomy of the Operative Note

- Findings and Procedure(s)
  - Brief statement of medical necessity
    - Detailed diagnosis based on findings
    - Nature/duration of problem
    - Discusses special circumstances such as failed prosthesis or hardware and/or post-op infection.
    - Planned return to OR
    - Summary of operations
    - Intra-operative findings

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Findings

FINDINGS: After extensive exploration of the abdomen we identified two anterior gastric wall possible microperforations secondary to a buckshot injury. No further bowel injury was identified. The remainder of the exploratory laparotomy was negative.

Anatomy of the Operative Note

- The Procedure Note
  - Site of operation
  - Operative Access
  - Dissection (Where did the surgeon end up?)
  - Where there any problems with dissection, or identifying anatomical landmarks

Anatomy of the Operative Note

- The Procedure Note
  - Dissection (continued)
    - What was removed or opened (-Otomies, versus -ectomies)
    - Was tissue, bone or some other spare part harvested locally or from a separate site?
    - Was the work intra or extra-articular or in a specific body cavity.

PROCEDURE:

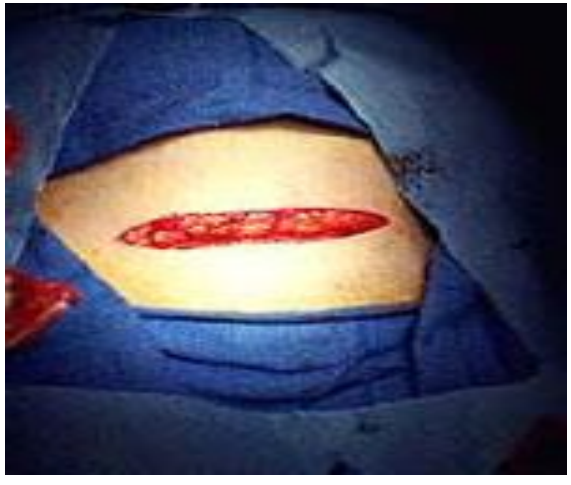
1. The patient was brought to the OR and placed on the OR table in a supine position.

2. After induction of anesthesia he was prepped and draped in a sterile fashion.

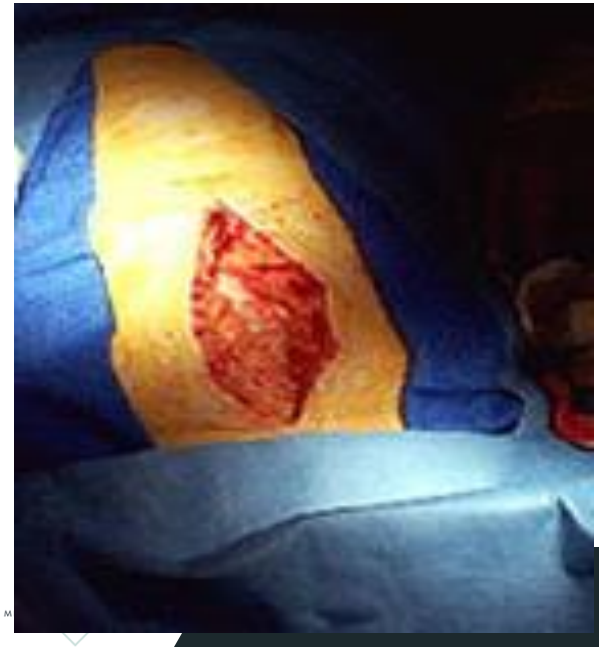
3. A midline incision from the xiphoid to the pubic symphysis was made using sharp dissection.

4. The electric Bovie cautery was used to incise down to' the level of the fascia.

Abdominal Incisions



Pfannenstiel (Bikini) incision (between 6 and 12")



Midline incision (between 6 and 14")

PROCEDURE:

The peritoneum was entered. All quadrants were explored.

1. The left upper quadrant did show an intact liver without any nodules, masses, or injuries.

2. This was also evident in the left upper quadrant.

3. The pelvis and the lower quadrants were also without any evidence of injury.

PROCEDURE:

4. The ligament of Treitz was identified and the small bowel was run proximal to distal.

4. The colon was then identified and inspected along its length down the extension down to the pelvis.

5. There was no evidence of any blood or free fluid throughout any of this exploration. In addition, there was no evidence of succus or stool within the abdomen.

PROCEDURE:

- At this point we did a closer inspection of the stomach.
  - The greater omentum was opened, and the posterior wall of the stomach was exposed, this was inspected in full.
    - Although on the CT report a posterior gastric wall hematoma was identified, none was evident upon visualization.

PROCEDURE:

- A further inspection of the anterior wall of the stomach demonstrated two anterior gastric medial wall possible microperforations.
  - These were not actively expressing any gastric contents, but actually appeared to have been sealed over, but buckshot was evident within the wall of the stomach.

Anatomy of the Operative Note

- Definitive work
  - Removal , Repair, Reconstruction
  - Fixation, Loosening, lengthening, shortening
  - Hardware in versus out (Plates, Screws and Rods)
  - Graft and Source
  - Debridement
  - Complex closure

PROCEDURE:

- At this point two 3-0 single Lembert

  –stitches were placed to oversew

  each of the two microperforations.

Anatomy of the Operative Note

- The Procedure Note
  - –Closing maneuvers
    - Closure (primary, simple, complex, delayed)
    - Immobilization (casts, strapping, external fixation)
    - Insertion of device e.g. electrical bone stimulator
    - **Signature(s)!**

PROCEDURE:

- After this was completed we ran the small bowel again to confirm that there was indeed no injury.
  - Again no injury was identified.
  - At this point we felt satisfied with our exploration of the abdomen.
  - A 0 PDS was used to close the fascia with a running suture. Staples were then used to close the skin.
  - The midline wound was dressed with a sterile dressing.
  - The drapes were taken down.

Choosing CPT Procedural Codes

- Determine Anatomical Site
- Determine Type of Surgical Access
- Determine what was done
- Choose and apply the CPT code that is most appropriate for what was documented.

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Choosing the Correct CPT Code(s)

- Exploration VS Gastrorrhaphy
  - **43840** VS 20102
    - 43840 Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound or injury
    - 20102
      - Includes foreign body removal
      - Debridement
      - Open examination
      - Coagulation of small blood vessels
      - Wound expansion

Choosing the Correct CPT Code(s)

- 49000 VS 43840
  - –49000 is **(Separate Procedure)**
    - Seemed to account for most of work….
    - Worth 18.49 RVU
  - –43840 worth 23.80 – Definitive procedure

Choosing Modifiers

Determine whether the documentation presents any special surgical circumstances?

Choosing Modifiers

- Triage modifiers
  - Identify primary procedure by RVU value
  - Identify
    - modifier “-51 exempt” and
    - “add-on” services.

Choosing Modifiers

- Triage modifiers (continued)
  - Identify laterality issues (modifier -50, HCPC modifiers for digits)
  - Identify services subject to multiple procedure reductions (modifier -51).
  - Identify unusual circumstances for bundled services (modifier -59)

Documentation Modifier 59

- Must state – Circumstances for Distinct Procedure or Service (Modifier –59), look for the 3 Ss
  - **Separate Surgeon**
  - **Separate anatomical site**
  - **Separate Session**

Choosing Modifiers

- Bilateral - 50 versus LT and RT
  - -50 Same procedure both sides
  - LT and RT different procedure on different sides,
    - Without laterality modifiers, the procedures might be bundled if done on the same side, or same digit
  - HCPCS
    - E1-E4 Eyes
    - F1 – FA Upper extremities
    - T1 – TA Lower extremities

Choosing Modifiers

- Triage modifiers (continued)
  - Identify global surgery issues
    - Repeat procedure by same provider (-76)
    - Planned or staged procedure (-58)
    - Return to OR for related procedure (-78)
    - Return to OR for un-related surgery (-79)
    - Incomplete package (54, 55, 56)

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Choosing Modifiers

- Triage modifiers (continued)
  - Identify special circumstances
    - Unusual or difficult procedures (-22 modifier)
    - Reduced services (-52 modifier)
    - Discontinued services (-53 modifier)

Documentation Modifier 22

- Document amount prolonged operative time from normal
  - Circumstances can include, but not limited to
    - Intraoperative hemorrhage
    - Intraoperative seizure
    - Untoward reaction to anesthesia or antibiotic
  - Drop to paper claim or upload electronic file with operative note and cover letter.

Documentation
Modifier 22

- Document amount of prolonged operative time from normal to achieve dissection due to abnormal anatomy, and cite due to:
  - –Irradiation
  - –Infection
  - –Scarring or adhesions
  - –Prior surgery
  - –Trauma
  - –Congenital Anomaly
  - –Invasive tumor

Documentation Surgical Modifiers

- Need to state if procedure has been discontinued and why (Modifier -53)
  - Must have started procedure and anesthesia
  - Usually there are adverse indications to the patient for procedure to continue, e.g. patient is too hypotensive to continue
  - Reduction of fee is at provider discretion

Documentation Surgical Modifiers

- Need to state if procedure or service was reduced, note what was reduced and why (Modifier –52)
  - –Part of procedure reduced or eliminated at discretion of physician, e.g., can not do full surgery because the part you planned to work on had been previously removed.
  - –Reduction of fee at physician discretion

Choosing Modifiers

- Triage modifiers (continued)
  - Identify multiple providers
    - Assistant at surgery (80, 81, 82)
    - Co-surgery (-62)
    - Surgical team (-66)
      - Don't see much, capitated

Modifiers
Assistant at surgery

- **Modifier 80** - Assistant at surgery
- **Modifier 81** - Minimal assistant at surgery
- **Modifier 82** - Assistant at surgery (when a qualified resident surgeon is not available)
- Check **payer policy** for nurse first assist, regardless of special credentialling some payers will not reimburse

Surgical Assistant

- No special documentation required from the assistant
- Attending operative notes should indicate assistant at surgery and name in the operative note preamble.
  - Best practice to mention in course of surgery

Modifier -82

- Section 100.1.7 clm104c, chapter 12 IOM as of 02/13/2006
  - Qualified Resident not available
  - Must cite Medical Necessity
  - Emergency situations
  - Life threatening situation e.g. multiple trauma
  - "Exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available"

Modifier -82

This certification is for use only when the basis for payment is the unavailability of qualified residents:
“I understand that section 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier.”

CPT Direction Modifier -62

- “When two surgeons work together as primary surgeons performing distinct parts of a procedure, each surgeon should report his/her distinct operative work by adding the modifier ‘-62’ to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once, using the same procedure code. If additional procedure(s) (including add-on procedure(s), are performed during the same surgical session, separate code(s) may also be reported with modifier ‘-62’ appended.”

- CPT Assistant 09/02

CMS Direction Modifier 62

- If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-62."
- Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the MFSDB. (See §40.8.C.5.);
- 40.8. - Claims for Co-Surgeons and Team Surgeons (Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)
- clm104c12.pdf

Co-Surgery

- Single Shared Approach (e.g., Anterior Spine)
- Same Code used by General Surgeon and Neurosurgeon
- Fee is increased by 25%
- Fee is Split 62.5% each MD

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Co-Surgery Claims Submission

- Submit paper claim with both operative notes, an interdepartmental or cross office coordinated effort.
- Need operative note from each surgeon
  - Due to definition each is doing their own piece
- Need cover letter for medical necessity

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Modifier 63

- - Modifier 63 – Procedure performed on infants less than 4KG.
  - For use only on surgical CPT codes (20000 – 69999), unless otherwise designated.
  - Some codes such as the repair of truncus arteriosus (33786) have parenthetical notes instructing the coder not to append a modifier – 63.

Unlisted Codes

- Use when there is not a CPT Code to adequately describe the service
- Submit paper claim
  - Operative note
  - Letter describing procedure, supporting research, clinical efficacy, and resulting cost savings if applicable
  - Compare to established CPT code (s) that most closely describe the service to establish a basis for pricing
    - Calculate a percent up or down from value for established procedure code and support your fee configuration in the letter.

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Unlisted Codes

- Pricing
  - –Compare to established CPT code (s) that most closely describe the service to establish a basis for pricing
    - Calculate a percent up or down from value for established procedure code and support your fee configuration in the letter.

Operating Microscope

- Use 69990
  - An add on code
  - No modifier -51
  - Must document use of operating Microscope
    - Not for Loupes
    - Procedures with “microdissection” in the definition of the service already include this.

Questions

elevate

MEDICAL SOLUTIONS

THANK YOU

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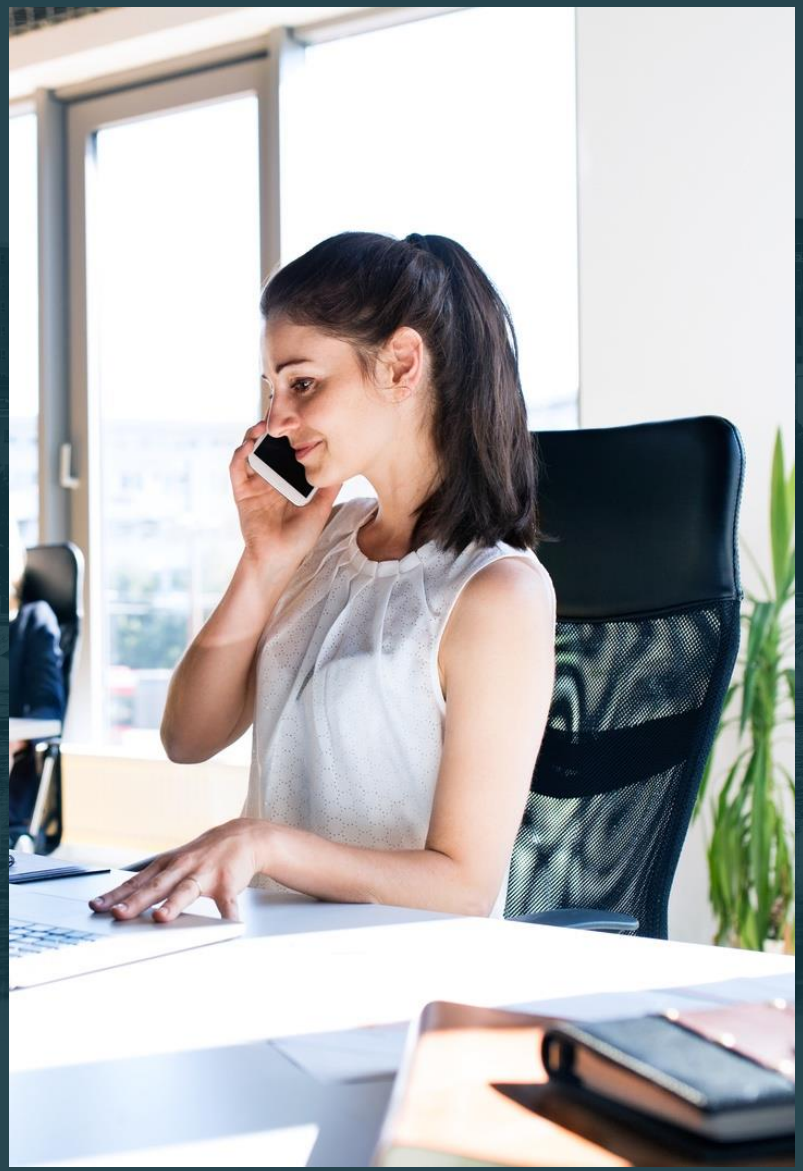

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ELEVATE AT A GLANCE

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