Reimbursement: Assistant Surgeon

September 15, 2016

Question:
What is the reimbursement for an assistant surgeon using modifier 80? Is the payment different for the primary and the assistant?

Answer:
Assistant surgeon is described as one surgeon, of the same or a different specialty, providing assistance during a surgical procedure or CPT code. Modifier 80 (modifier 82 for an assistant surgeon in an academic setting when a qualified resident is not available) is appended to any CPT code the assistant participates in. Medicare reimburses 16% of the allowable for the assistant surgeon (modifier 80 or 82), to the codes where an assistant payment is allowed, and multiple procedure/bilateral procedure reductions also apply. The primary surgeon’s fee is not affected. In an assistant surgeon scenario, the assistant need not and should not dictate a separate note. However, it is critical that the primary surgeon document in his/her note, specifically what the assistant did. Stating an assistant was needed because the case was complex is not sufficient. The primary surgeon must state what the assistant did, for example, assisting with the resection, anastomosis, etc. For private payers, coding guidelines and payment may vary.

*This response is based on the best information available as of 09/15/16.*
Reimbursement: Co-Surgery

September 1, 2016

Question:
What is the reimbursement for co-surgery using modifier 62? Is it different for the primary and co-surgeon?

Answer:
For Medicare, co-surgery requires two different specialties performing separate parts of a single CPT code. For both surgeons, modifier 62 is appended to the appropriate CPT code(s). Medicare multiples the allowable by 125% and splits the reimbursement exactly in half, resulting in a payment of 62.5% to each surgeon. For example, when plastic surgery and neurosurgery do a craniosynostosis procedure together using 61559 then each surgeon reports 61559-62. So to answer your question, the payment is the same for both surgeons. Both surgeons dictate an operative note describing their work and both have post-operative responsibilities. For private payers, coding guidelines and payment may vary.

*This response is based on the best information available as of 09/01/16.

Surgical Modifiers: How Do
**They Impact Reimbursement?**

August 18, 2016

**Question:**
What reimbursement should we expect when using the global period modifiers 58, 79 and 78?

**Answer:**
Surgical modifiers are used to indicate that a subsequent procedure was performed during the global period of a prior surgery. Modifiers tell the payer the rationale for allowing payment for this subsequent procedure. The modifiers and reimbursement impact of each is shown below:

Modifier 58: to indicate a second procedure was performed as a staged procedure. Reimbursement should be 100% of the allowable fee.

Modifier 79: To indicate an unrelated procedure was performed during the global period of the original procedure. Reimbursement should be 100% of the allowable fee.

Modifiers 78: To indicate that a complication of an original procedure was treated by a return to the operating room, catheterization or endoscopy suite. Reimbursement should be at 70-80% of the allowable fee. This reduction reimburses for the intra-operative portion of the procedure only, since the patients pre and post-operative services are paid under the original surgery’s flat fee.

*This response is based on the best information available as of 08/18/16.*
Look for an upcoming KZA Webinar on “Modifiers for surgeons: What you need to know”, which will cover modifiers 22, 59, 58, 79 and 78.

Also stay tuned for another KZA webinar “Surgeon Role Modifiers. Co-surgeon, assistant Surgeon, or coding separate codes: current coding and documentation Guidelines.

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**Medicare X Modifiers: Use or Not Use?**

August 4, 2016

**Question:**
What’s new with the X modifiers established by Medicare? Should we be using them now?

**Answer:**
As of today, Medicare has yet to finalize a formal policy for the use of the -X{EPSU} modifiers as a replacement for modifier 59. The -X{EPSU} modifiers are shown below but have not yet been well defined by Medicare.

- **XE:** Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- **XS:** Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- **XP:** Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- **XU:** Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service
At this point, Medicare has given practices the option to use the -X{EPSU} modifiers or the 59 modifier. Some of our clients tell us that they are using the -X{EPSU} modifiers without any payment issues. We suspect that the -X{EPSU} modifiers will eventually become standard Medicare policy since the intent of these modifiers is to force providers be more specific regarding the rationale for unbundling two bundled CPT codes. Medicare developed these modifiers to reduce misuse and abuse of modifier 59.

Remember, Medicare prefers reporting multiple units of add-on codes by indicating the number in the units box. For example, report +13133 x 2 units (not 13133, 13133-59). The point is to reduce the utilization of modifier 59.

*This response is based on the best information available as of 08/04/16.

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Source for a Consult

July 21, 2016

**Question:**
What is an appropriate “source” for a consult? I asked at a recent workshop (not a KZA workshop!) and the instructors did not have an answer.

**Answer:**
The guidelines for a consultation (inpatient or outpatient) must be requested by a physician, or qualified non-physician practitioner. Guidelines are not clear regarding individuals who may be considered an appropriate source, but some likely
examples include a physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech language therapist, psychologist, social worker, lawyer, or insurance company.

Do not report a consultation requested by a patient or family member, etc., using a consultation code.

*This response is based on the best information available as of 07/21/16.

New Patient Visit and Modifier 57

July 7, 2016

**Question:**
If I see a new patient and during that visit I identify the need for surgery the same day, can I append a Modifier 57 to the E/M service and get paid?

**Answer:**
You determine during the evaluation that the patient would need surgery the same or next day for a major procedure (90 day global), append Modifier 57 to the E/M service. If the procedure is a minor procedure with at 10 day global and the E/M service is significantly separately identifiable, then report the E/M service with Modifier 25.

Use caution when appending the 25 Modifier as CMS has indicated that there is an inherent E/M service in every procedure and routine use of Modifier 25 may create payer
Signing NPP Notes

June 23, 2016

Question:
Do I have to sign each of my NP’s notes that are reported incident-to?

Answer:
The guidelines for reviewing and signing NPP documentation are set by each state in its scope of practice regulations. Each practice must research those requirements individually. But as an employer, you are responsible for the care provided by the NP, and reviewing and signing off on the notes may be an efficient method for keeping tabs on patient treatment.

*This response is based on the best information available as of 06/23/16.

Modifier 57: Decision for
Surgery

June 9, 2016

Question:
I saw a patient on a Friday and scheduled elective surgery for the following Monday. Do I need a 57 modifier on the E/M code I did on Friday?

Answer:
Modifier 57 is required on an E/M code that is the decision for surgery visit if the visit occurs the day before or the day of a major procedure, meaning a procedure with a 90-day postoperative global period. When the decision making E/M service occurs outside of that range (day before or day of a major procedure) then modifier 57 is not necessary.

*This response is based on the best information available as of 06/09/16.

Three Layer Closure = Complex Repair?

May 26, 2016

Question:
Is a 3-layer closure after a malignant skin lesion removal considered a complex repair code (131xx)?

Answer:
No. Actually, CPT says a “Complex repair includes the repair of wounds requiring more than layered closure, viz., scar revision, debridement (e.g., traumatic lacerations or
avulsions), extensive undermining, stents or retention sutures.” The emphasis (bold) is added to show that a complex repair code requires more than a layered closure. The intermediate repair (12xxx) code guidelines say a “layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure” is performed. The emphasis (bold) is added to show that one or more (e.g., two, three) layers repaired is considered an intermediate repair after excision of a skin lesion.

*This response is based on the best information available as of 05/26/16.

Transitional Care Management Codes

May 12, 2016

Question:
We’ve been using the transitional care management codes, 99495-99496, for post-op discharge care (e.g., writing prescriptions, dictating the discharge summary) while the patient is in the hospital after surgery for breast reconstruction or flap reconstruction procedures. Medicare has been denying the codes. Should we appeal these denials?

Answer:
No, don’t appeal the denials. Discharge care management is included in the 90-day post-operative global period for breast reconstruction and flap reconstruction procedures. The transitional care management codes have specific requirements, as noted in CPT resources, which are typically are performed
by the patient’s primary care physician.

*This response is based on the best information available as of 05/12/16.*