

# Dermatology Coding Alert

## Modifier of the Month: Ask These Questions to Code Assisted Procedures Correctly

**Don't underestimate the value of 'purpose' in deciphering modifiers 80, 81**

Many of the procedures your dermatologist provides - such as lesion removal or skin grafts - may require assistance from another physician, nurse or physician's assistant. But reporting these services accurately with CPT modifiers 80, 81 and 82 and HCPCS modifier AS can confuse even the most seasoned dermatology coder.

Ask yourself these five questions to choose the correct modifier in any assisted-procedure scenario.

### Question 1: Did you check the most recent fee schedule?

Although modifiers 80 (Assistant surgeon), 81 (Minimum assistant surgeon) and 82 (Assistant surgeon [when qualified resident surgeon not available]) each define an assistant at surgery, each has a distinct purpose, and the Physician Fee Schedule will get you headed in the right direction to figure the distinction out.

"Each year, as part of the Physician Fee Schedule, Medicare publishes those procedures for which they approve technical surgical assisting (TSA) by a physician, physician assistant (PA), nurse practitioner, or clinical nurse specialist," says **Ron L. Nelson, PA-C**, president and CEO of Health Service Associates Inc., a healthcare consulting firm in Fremont, Mich.

### Question 2: Did the assisting physician act as 'an extra set of hands'?

Modifier 80 may be the most commonly used modifier of the three. You should append modifier 80 if one physician acts as the primary physician's "extra set of hands."

**Red flag:** Do not confuse modifier 80 with modifier 62 (Two surgeons), which describes two physicians acting as co-surgeons.

Section 15044 of the Medicare Carriers Manual specifies that each physician serve as the primary physician during some part of the operation and that each perform a distinct portion of a single reportable procedure (if each physician performs a separately reportable procedure, even during the same operative session, they are not co-surgeons), says **Linda Martien, CPC, CPC-H**, National Healthcare Review in Woodland Hills, Calif.

Although the physician completes a procedure on the same patient during the same operative session, they in fact work independently of one another.

Note that a single physician can serve as co-surgeon and assistant physician during different portions of the same operative session.

**Example:** The dermatologist in your multi-specialty practice assists a general physician with a simple repair of a superficial wound on a patient's face that measures 20.5 cm (12017, Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm).

The dermatologist assists throughout the procedure, and the primary physician documents that the dermatologist acted as his "extra set of hands."

**Modifier solution:** The 2005 Physician Fee Schedule designates code 12017 with a "0," which means that your carrier will determine whether you can report an assisted procedure based on your documentation.

### Question 3: What number appears in Column U?

If the fee schedule lists a "2" in Column U ("Assistant at Surgery"), you can bill a surgical assist. For example, Medicare lists code 12018 (Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm) as payable for an assist.

If Column U bears a "0," your documentation will make or break your assistant's reimbursement odds, Martien says.

When this column lists a "0," reimbursement "for assistants at surgery cannot be paid unless supporting documentation is submitted to establish medical necessity," according to the policy of AdminaStar Federal (a Part B carrier in Indiana),

You should submit your operative report with these claims to demonstrate why the physician required an assistant.

Medicare assigns the "0" indicator to code 12037 (Layer closure of wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; over 30.0 cm), so you should only bill for a surgical assistant during these procedures if the physician is certain that he can demonstrate medical necessity to the patient's insurer, Martien says.

**Note:** For more information on the assisted surgical status of many common dermatology-specific codes, see "Clip-and-Save Chart: Keep This Tool at Your Fingertips to Solve Modifier 80 Mysteries" in the next article.

### Question 4: Who provided the assistance?

Modifier 81 specifies "minimum" assistant surgeon, but neither CPT nor CMS provides definitive guidelines to help physicians and coders distinguish a minimum assistant from a "regular" assistant as described by modifier 80. This absence of clarity causes payers to interpret modifier 81 differently.

"I believe that the original intent of the modifier [81] was to offer physicians a way to bill when they only came in and helped with a small portion of the surgery but didn't stay and assist for the whole procedure," says **Marcella Bucknam, CPC, CCS-P, CPC-H**, HIM program coordinator at Clarkson College in Omaha, Neb.

"Now, however, modifier 81 is most often used when the assistant is not another surgeon - and especially with midlevel assistants," Bucknam says. "At this time, I don't know of any insurers who like the modifier except for a few that want it when a nonphysician assists in the operating room."

If the insurer pays, the rate for 81 is usually 10 percent of the full surgeon's fee, she says. But other insurers will reimburse for surgical assistants, physician assistants (PAs) and other nonphysician practitioners acting as assistants at surgery with modifier 80 (although usually at a reduced rate).

**Example:** The dermatologist in your multi-specialty practice assists the general surgeon with a superficial facial wound measuring 32 cm. The dermatologist does not stay in the OR for the entire procedure. Your carrier has specified that you should use modifier 81 in these cases, so you report 12018-81.

The dermatologist receives \$31.75, based on 10 percent of the surgeon's fee (\$317.58 - 8.38 RVUs times the 37.8975 conversion factor).

### Question 5: Do you have special instructions in writing?

Technically, only a physician fully licensed to practice medicine may report modifier 80. Therefore, if a payer advises you to use modifier 80, be sure you obtain instructions in writing to cover yourself in case of a retrospective review. |

**Bonus:** Unlike some private payers, Medicare will allow only physicians to report modifier 80. But Medicare has eliminated all of its HCPCS modifiers for PAs except modifier AS (Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery) for first assisting.

Specifically, Medicare will reimburse for the services of a clinical nurse specialist, physician assistant, and nurse practitioner as assistants at surgery.

Medicare will not reimburse for surgical assistants such as registered nurse first assists, licensed practical nurses, and certified surgical technologists.

A few non-Medicare carriers use modifier AS also, but that it is not typical for most private carriers, so make sure you check with specific carriers.

CPT limits the use of modifier 82 to teaching hospitals, and you should use it only if a qualified resident is not available to assist.