Part B Insider (Multispecialty) Coding Alert

Modifiers: Mind Your Modifiers When Your Physician Acts As Co-Surgeon

Coordinate surgeon claims or chance missed reimbursement

When coding surgical claims, pay special attention to whether a second surgeon works with your surgeon to provide the approach and closure portions of the procedure. If so, you'll have to take some additional steps to gain fair payment.

Look to Modifier 62 for Co-Surgeons

When two surgeons work together to perform distinct portions of a procedure CPT identifies with a single reportable code, you'll need to access modifier 62 (Two surgeons).

For example, suppose a neurosurgeon is performing an anterior approach arthrodesis, and requests that a general surgeon exposes the surgical area and closes the patient following the procedure. The neurosurgeon performs the arthrodesis, along with related bone graft and instrumentation procedures.

"When a general surgeon does the exposure for a spine case, modifier 62 is used," says **Myra P. Anderson, CPC, CCAT, CPAT,** coding educator with Ochsner Health System. "Both surgeons are performing distinct portions of the procedure," she notes.

Both the neurosurgeon and general surgeon should report the same CPT and diagnosis codes, advises **Lori Longeway, CPC**, coder with the University of Toledo in Ohio. She recommends sending a copy of the operative notes from both physicians with your claim.

For example: A general surgeon and neurosurgeon work together during arthrodesis for interspaces T6-T7, T7-T8 and T8-T9 using an anterior approach for interbody technique. Additionally, the neurosurgeon packs the interspaces with morselized allograft and places anterior instrumentation with attachment points at T6, T7, T8 and T9.

In this case, both the general surgeon and neurosurgeon will report 22556 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace [other than for decompression], thoracic) and append modifier 62 for the initial interspace (T6-T7) and +22585-62 x 2 for the additional interspaces (T7-T8 and T8-T9).

Only the neurosurgeon will report the bone graft (+20930, Allograft for spine surgery only; morselized [list separately in addition to code for primary procedure]) and instrumentation placement (+22846, Anterior instrumentation; 4 to 7 vertebral segments [list separately in addition to code for primary procedure]) because the general surgeon did not assist in these procedures. (Note, in addition, that CPT instructions prohibit modifier 62 with spinal bone graft and instrumentation procedures).

Cooperation Matters in Coding, Also

When reporting co-surgeries, you should work closely with the other operating surgeon's staff to ensure that each practice gets its fair share of the reimbursement. "Both doctors need to dictate their own portion of the procedure in order to fulfill the requirements of the co surgeon modifier," advises **Cheryl Ortenzi, CPC, CPC-I,** manager of billing and compliance with BU Plastic Surgery Associates and senior project manager with Boston Medical Center Faculty Practice Foundation.

Medicare and most other payers reimburse procedures coded with modifier 62 at 125 percent of the regular fee schedule amount. The payer divides this between the two surgeons reporting the procedure, so each surgeon receives 62.5

percent of the standard fee. Don't change your fee in anticipation of the adjustment, however. Charge your normal fee for your physicians' services, and allow the insurer to make the adjustment, both Longeway and Anderson advise.

To ensure that both physicians receive proper payment correctly, follow four guidelines:

1. Each physician should document his own operative notes, detailing what portion of the procedure he performed, how much work was involved and how long the procedure took.

2. Each surgeon should identify the other as co-surgeon.

3. The co-surgeons should link the same diagnosis to the common procedure code.

4. Each physician should submit his own claim with his own documentation, and diligently note both the work he performed and that of the other physician.

If claims are filed incorrectly, usually whichever surgeon gets his claim in first gets paid " and the other does not.

Check Fee Schedule for Modifier Advice

To confirm that the procedure you wish to report qualifies for modifier 62, turn to the Medicare physician fee schedule (MPFS) database. To be eligible for payment, make sure that the procedure codes have a Medicare co-surgery indicator of either "1" or "2." If not, your physicians cannot code and bill as co-surgeons for that procedure.

1: If you find a code carries a co-surgery indicator of "1," you must supply documentation to establish medical necessity for two surgeons. Only when you establish medical necessity clearly will a payer consider additional reimbursement, say experts. You should present which circumstances in the procedure require special skills or expertise by two surgeons sharing a responsibility.

2: A "2" in the co-surgery column indicator means that you may append modifier 62 as long as each of the operating surgeons is of a different specialty. Code 34802 (Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis [one docking limb]), for example, has a "2" in the co-surgery column.

Resources: You can search the Medicare physician fee schedule online at www.cms.hhs.gov/pfslookup. And if you download the 2010 files available at www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp, you can find modifier indicator definitions in the file "RVUPUF10."