Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Fee Schedule School's Back In Session

Add columns U, V and X to your stock of skills

Last month's PBI showed you the ropes for tracking RVUs, global periods and bilateral indicators. Now complete your fee schedule education with a crash course on surgery categories.

Count On Column V For Co-Surgeon

Not every CPT code is eligible for reimbursement with a co-surgeon. Determine when you can use modifier 62 (Two surgeons) by looking to column V in the Excel version of the **fee schedule** database (see inset for details on accessing the database).

Remember: For modifier 62 claims, most payers pay an additional fee (generally 125 percent of the "usual" fee for the procedure, split evenly between the two surgeons). Avoid reimbursement problems by checking these claims carefully, says **Stephanie Collins, CPC**, healthcare consultant with **Gates, Moore & Company** in Atlanta.

Crack The Column V Code: A "2" in column V next to the code you're investigating means that Medicare will pay for a co-surgeon for that procedure, as long as each surgeon is of a different specialty.

A "1" in column V indicates that Medicare may pay for a co-surgeon, but you must submit documentation to explain the medical necessity for a co-surgeon.

In contrast, a "0" means that Medicare will never pay two surgeons for the service, while a "9" means that the concept of co-surgery does not apply for that particular code (and therefore you should never apply modifier 62).

Example: Medicare considers most wound repairs to be relatively simple procedures and therefore not eligible for payment with a co-surgeon. For instance, the database assigns a "0" to column V for codes 12001-12006, meaning that you cannot be reimbursed with a co-surgeon with these procedures.

But for more extensive repairs, such as those described by 12007 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; over 30.0 cm), CMS assigns a "1" to column V, meaning that Medicare may pay for a co-surgeon if documentation clearly explains why this is warranted.

Remember: To claim co-surgeons, each surgeon must perform a distinct portion of a single CPT procedure, and each surgeon must dictate and submit his own operative report for his portion of the surgery, says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME,** president of CRN Healthcare Solutions in Shrewsbury, NJ.

Follow Similar Criteria For Assistant Surgeons

If you're looking to bill for an assistant surgeon with modifier 80 (Assistant at surgery), you can follow the same guidelines stipulated for co-surgeons, but look instead to column U of the fee schedule database.

A "2" in column U means that Medicare will pay for an assistant surgeon without further review (such cases are rare). A "1" means that Medicare will pay for an assistant with explanatory documentation. A "0" means that Medicare will never pay for an assistant surgeon, and a "9" means that the concept of assisted surgery does not apply.

As with co-surgeons, insurers pay an additional fee for assistant surgeons (usually 16 percent of the surgical fee in

addition to 100 percent reimbursement for the primary surgeon), and therefore review assistant surgeon claims carefully, Cobuzzi says.

Example: In the operating room, the surgeon debrides necrotizing soft tissue of the external genitalia and abdominal wall, including fascial closure (11006, Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure). Because of the procedure's relative complexity in this case, the surgeon requests another surgeon to serve as a "second pair of hands" during the operation.

In this case, you may append modifier 80 to 11006 for the assistant surgeon, as long as you supply supporting documentation, because the fee schedule assigns 11006 a "1" in column U.

Scope Out Multiple Endoscopy Rule

When coding for multiple endoscopies of the same type (sigmoidoscopy, colonoscopy, etc.), you must take into account the multiple endoscopy rule. The fee schedule database can help by allowing you to identify the parent or "base" endoscopic procedure.

The multiple endoscopy rule is CMS' method to avoid paying twice (or more) for "inclusive" services by reimbursing only a portion of any endoscope performed at the same time as another endoscope of the same basic type, says **Tara L. Conklin, CPC,** an instructor for **CRN Institute**. The rule applies only if two or more endoscopies the surgeon performs have the same base code, Conklin says. And, you should always include base endoscopies in more extensive endoscopies of the same type.

'X' Marks the Spot

To find the endoscopic base code for any endoscopic procedure, look to column X of the **Physician fee schedule** database. If there is no code in column X, either the code you are checking is not an endoscopic procedure or the procedure itself is a base code.

Example 1: The surgeon performs a diagnostic sigmoidoscopy (45330, Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen[s] by brushing or washing [separate procedure]) plus sigmoidoscopy with control of bleeding (45334, ...with control of bleeding [e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator).

If you check the database's column X, you'll notice that 45330 does not have a base code. That's because 45330 is the base code ...quot; and is, in fact, the base code for 45334. In this case, you can only report 45334 because the base procedure (45330) is already included in 45334.

Example 2: During the same session, the surgeon performs colonoscopy for control of bleeding (45382, Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding [e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) and tumor ablation (45383, ...with ablation of tumor[s], polyp[s], or other lesion[s] not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique).

In this case, both procedures have the same base code (45378, ... diagnostic, with or without collection of specimen[s] by brushing or washing [separate procedure]). Therefore, you may report both procedures, but the insurer will only pay the full fee for the more extensive procedure (in this case, 45383) and will reduce the fee for the second colonoscopy (45382) by the value of the base procedure (45378). That's because the payer has already paid for the base procedure as a part of 45383, Conklin says.