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Part B Insider (Multispecialty) Coding Alert

Part B Payment: CMS Offers Great News With Fee Schedule Changes

Boost co-surgery, multiple surgery, and bilateral surgery pay for these select procedures.

You'll no longer have to eat the cost of your services if your physician acts as co-surgeon on some laparascopic procedures, thanks to several Medicare Physician Fee Schedule changes that CMS recently enacted. CMS offered up the following good news in Transmittal 2276, dated Aug. 19, 2011.

Look for Potential Co-Surgery Payment for These Codes

CMS will change the co-surgery indicator for hand surgery code 26989 (Unlisted procedure, hands or fingers) from "0" (Co-surgeons not permitted) to "1" (Co-surgeons could be paid, supporting documentation required to establish medical necessity of two surgeons for the procedure). Keep in mind that supporting documentation is required when billing for a co-surgeon with these procedures, so don't forget to submit that with your claim or you'll be looking at bad news.

The same rule holds true for the following laparoscopy codes (among others), which previously were not permitted with co-surgeons, but now also have a "1" indicator:

- 38129 -- Unlisted laparoscopy procedure, spleen
- 38589 -- Unlisted laparoscopy procedure, lymphatic system
- 43289 -- Unlisted laparoscopy procedure, esophagus
- 43659 -- Unlisted laparoscopy procedure, stomach
- 44238 -- Unlisted laparoscopy procedure, intestine (except rectum)

Remember: If you're billing for co-surgery, append modifier 62 (Two surgeons) to your procedure code. 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. 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.

Good News for 95925-TC

CMS also holds good tidings for practices who perform somatosensory testing (95925). In the past, the diagnostic supervision concept did not apply to 95925-TC, but that all changes thanks to CMS's new transmittal. Now the code has a diagnostic supervision indicator of "21," which means "Procedure must be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician."

Another positive change in this category comes for code 91132-TC. Whereas in the past, this code had a diagnostic supervision indicator of "3" (Procedure must be performed under the personal supervision of a physician), you'll now find it with a "1," which means it must be performed under the general supervision of a physician (note that this applies only when the TC modifier is appended to 91132).

What this means: The physician will no longer have to be present in the room during the procedure.

Here's why: Level 01 is general supervision, meaning that the doctor provides overall direction and control, but the service doesn't require his presence during the procedure. Level 03, however, means that the physician must be in attendance in the room during the procedure.

To read the CMS transmittal regarding the fee schedule changes, visit www.cms.gov/transmittals/downloads/R2276CP.pdf.