Part B Insider (Multispecialty) Coding Alert

Reader Question: Know the Rules for Assistant Surgeons

Question: I'd appreciate some help with how to bill for the following scenario for a patient with a vena cava thrombus during a kidney removal:

Physician A and an assistant physician B, both in the same group, performed an open radical nephrectomy without taking regional lymph nodes. A vascular surgeon was called in to help with the evacuation of vena cava thrombus, which he performed with the assistance of physician A. Because the vascular surgeon is new to this area and is not credentialed, he will not be billing for his portion of the procedure.

Answer: You should bill 50230 (Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy) for physician A and 50230-80 (Assistant surgeon) for physician B. Notice that this code describes nephrectomy with regional lymphadenectomy and/or vena caval thrombectomy, so the fact that lymph nodes were not taken doesn't impact the code choice, and you don't have to report "reduced services."

Since physician A participated in the thrombectomy and the vascular surgeon is not going to bill, you should list surgeon A as the primary surgeon and surgeon B as the assistant. Recall that an assistant surgeon doesn't have to be present for the entire procedure or all parts of the procedure. Also note that thrombectomy work can be quite various for different cases, from a fairly minor component to an extensive thrombectomy, so Surgeon A's work, whatever it was, can be used to bill the code.

Caveat: There are a couple of other factors you should take into consideration. For one thing, you should bill this code for Surgeon A only if he describe the thrombectomy as part of his op note, even if it says the vascular surgeon also worked on it. However, if surgeon A documents only that he assisted the vascular surgeon "see his note for details" or something like that, you should not list 50230. Instead, you should bill only for the nephrectomy (e.g., 50220, Nephrectomy, including partial ureterectomy, any open approach including rib resection) and leave the thrombectomy money on the table. Without a description of the thrombectomy as part of surgeon A's report, it would never stand up to review if that was needed.

Final caution: Some payers are pretty tough on the subject of having physicians who are not credentialed with the payer providing services for their patients. You need to be aware of payer rules before you bill this case.