

Socioeconomic tips of the month

Reporting an altered surgical field, modifier -60

A new modifier for reporting an altered surgical field, modifier -60, was included in the 2001 version of the *Current Procedural Terminology* (CPT) manual. However, Medicare and perhaps some other payors are not recognizing this new modifier. The "CPT Changes in 2001" article in the January issue of the *Bulletin* provided a brief summary of the purposes of the new modifier and how to use it. This article provides more recent and detailed information.

CPT 2001

Modifier -60, altered surgical field, is intended for use when a surgical procedure involves significantly increased operative complexity and/or time in a field that has been altered by the effects of prior surgery (including marked scarring or adhesions), inflammation or infection, distorted anatomy, irradiation, very low patient weight (that is, neonates and infants less than 10 kg) and/or trauma. In addition, the language for modifier -22, unusual procedural services, has been revised to indicate that services involving an altered surgical field should be reported using modifier -60 instead of modifier -22.

Reporting to Medicare

The Health Care Financing Administration (HCFA) has issued an instruction telling carriers not to recognize modifier -60 for payment purposes. The instruction indicates that surgeons are to continue to report surgical procedures that involve significantly more complexity and/or time due to an altered surgical field using modifier -22, unusual procedural services. Medicare carriers are instructed to continue using existing, pre-2001 policies and procedures with respect to modifier -22 to determine reimbursement. Medicare secondary payors also will accept modifier -22.

Generally, Medicare carriers require two pieces

of additional documentation when modifier -22 is used. The first is a special report from the surgeon requesting additional reimbursement and summarizing in one or two paragraphs why the service or procedure was unusual and the work substantially greater than usual; the second is a copy of the operative report. Please refer to "Socioeconomic tips of the month" in the June 2000 *Bulletin* for a more detailed discussion of reporting modifier -22.

Surgeons and their billing staffs should read the article in their local Medicare carrier bulletin on this departure from CPT's intended use, especially because there may be some local carrier information that is of interest. It is possible that local carriers published this information earlier this year.

Reporting to other payors

Payors that do not recognize many modifiers probably will not recognize modifier -60. On the other hand, some payors want to comply with CPT rules and will develop policies regarding modifier -60. However, as with the -22 modifier, surgeons should not routinely use modifier -60. As the CPT definition says, modifier -60 should be appended only when the procedure involves "significantly increased operative complexity and/or time in a significantly altered surgical field," so be sure the standard for "significantly" is met. Also, there are some specific instances in which the use of the modifier is inappropriate. For example, the modifier should not be reported (or should be reported very infrequently) if the code already has the modifier "built in" (that is, the code is for a reoperation or the code is used specifically for neonates or infants weighing less than 10 kg). Finally, do not be surprised if payors request documentation, much as they do for modifier -22, unusual procedural services.

What happened

Many surgeons believed there would be more uniform recognition of additional work in an al-

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continued on page 55

tor, at 937/586-3717, or write to her at jane_treiber@mei.meinet.com. (Note: To view the chapters' online versions of their "survival manuals," visit the chapter Web sites at http://www.facs.org/fellows_info/acs_chapters/acschapt.html.)

France Chapter honors Professor Murat

The France Chapter has named John R. Murat, MD, FACS, Honorary Governor of the France Chapter; Dr. Murat previously served as the Governor of the chapter. This recognition was extended to Dr. Murat for his longtime contributions to the France Chapter; he was a founding member, and he served as President and Secretary-Treasurer as well. In April 2001, the chapter will conduct its first Spring Meeting, which will focus on colon and rectal cancer and laparoscopy.

Louisiana Chapter conducts 49th annual meeting

The Louisiana Chapter conducted its 49th annual meeting on January 20-21 in New Orleans, LA, in conjunction with the Surgical Association of Louisiana (SAL). Barry Landry, MD, FACS, SAL President, opened the educational program with a report on his volunteer surgery activities in South

America. He reported that his mission was a "life-changing" event, and he encouraged other Fellows to participate in these types of surgical missions. The program featured presentations by five visiting professors: Timothy Flynn, MD, FACS, Gainesville, FL; John S. Najarian, MD, FACS, Minneapolis, MN; Ronald Maier, MD, FACS, Seattle, WA; Phillip Caushaj, MD, FACS, Pittsburgh, PA; and David Herndon, MD, FACS, Galveston, TX. In addition, at the annual business meeting, J. Patrick O'Leary, MD, FACS, Chapter President, presented the M. L. Jarrell Traveling Resident Fellowship Award to Cheryl Ann Stanski, MD*, a resident at Tulane University in New Orleans, LA.

Chapter anniversaries

Month	Chapter	Years
March	Brazil	49
	Southern California	49
	Massachusetts	36
	Nevada	36
	New Hampshire	49
	Puerto Rico	51
	South Dakota	49
April	Metropolitan Chicago	46
	Mississippi	48
	Oklahoma	51

*Denotes participant in the Candidate Group.

SOCIOECONOMIC TIPS, from page 46

tered surgical field if they separated the operations having an altered surgical field from other surgical and nonsurgical services having the -22 modifier. Physicians felt that payors could more easily work out policies to govern use of the new modifier because it would not apply to as many codes. HCFA decided not to recognize the new modifier at all because of the agency's fear that the number of claims with the new modifier would increase, causing the number of claims requiring manual review to rise. However, HCFA did not voice these concerns publicly until after the 2001 edition of CPT had been "put to bed."

It appears that for 2001, the situation will be very confusing, with some payors instructing surgeons

to follow CPT 2001 guidelines and some payors instructing surgeons to follow CPT 2000 guidelines. The College and the CPT editorial panel are concerned about the situation and are working to have a single reporting mechanism in place for 2002. [Q](#)

This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Chicago staff of the Health Policy and Advocacy Department, tel. 312/202-5150; fax 312/202-5021; or e-mail HealthPolicyAdvocacy@facs.org.