

Socioeconomic tips of the month

Q. What is the correct method of billing for services provided by an assistant surgeon?

A. If one surgeon assists a primary surgeon and is present for the entire operation, or a substantial portion of the operation, then the assisting surgeon reports the same surgical procedure as the operating surgeon. The primary surgeon does not append a modifier to the procedure that he/she reports. The assistant surgeon reports the same CPT code as the primary surgeon, with modifier -80 appended. For minimum surgical assistant services, modifier -81 should be used.¹ In addition, payment for services of assistant surgeons is made only when the most recent national Medicare claims data indicate that a procedure has used assistants in at least 5 percent of cases based on a national average.

If the procedure is one that has a global package, the global period is assigned only to the primary surgeon. No one except the primary surgeon is linked to that particular global period of follow-up care if the operating surgeon provides all three components of the global surgical package.²

Medicare also covers the services of an assistant surgeon when the procedure is “medically necessary,” and when a qualified resident surgeon is *not* available to act as an assistant surgeon using modifier -82. (Review Appendix A in your CPT manual for modifier definitions.) The assistant surgeon is generally the surgeon who:

- Assists with lesser tasks than the primary procedures.
- Does not do a work-up on the patient preoperatively.
- Does not admit the patient for surgery.
- Does not dictate an operative report.
- Is not responsible for postoperative care.

(Note: The surgeon should establish the patient’s status—that is, observation, outpatient, and so on—when the consult is conducted.)

Private payors establish certain definitions/guidelines. Generally they recognize the -80 As-

sistant Surgeon modifier in the reporting of these services, if they recognize any modifiers at all. Almost all insurers have a “medical necessity” requirement for coverage, and some insurers write specific contracts that never pay for an assistant at surgery.

For more information about payments for assistants at surgery, please refer to *Physicians as assistants at surgery: 1999 study*, which is available by contacting the ACS Health Policy and Advocacy Department.

Q. When a consultation is performed in the ER should the service be coded as an outpatient consultation or as an ER visit?

A. Surgeons should code for the most appropriate category of Evaluation and Management (E/M) service provided. In this scenario, you would bill an outpatient consultation if the ER physician or attending physician requested the surgeon’s consultation or opinion. Outpatient consultation codes are used whether the patient is new or established, to report consultations provided in any outpatient or other ambulatory facility, including an observation care area or ER.

Follow-up visits in the consultant’s office that are initiated by the physician consultant should be reported with codes for established patient E/M services (99211-99215.) Consultation codes are constantly misunderstood and underutilized by surgeons. We have received reports of some insurers inappropriately down-coding consult codes to new patient visits. It’s important to understand the different categories of consultations. In addition, the amount of work a surgeon must perform as well as the rules for correct use vary. Review the CPT book for full descriptions. The designated categories are:

- Office or other outpatient consultations.
- Initial inpatient consultations.
- Follow-up inpatient consultations.
- Confirmatory consultations.

Q. A second surgeon was called into the operating room to perform a consultation. The finding of the consult resulted in the second surgeon performing a procedure during the same operative session as the first surgeon.

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Can the second surgeon code for both services he or she provided?


A. Three criteria must be met to code for a consultation:

- A physician or another appropriate source must request the consultation and document it in the patient's medical record.
- The physician must document the encounter.
- The consultant's opinion must be communicated to the requesting physician and be documented in the patient's medical record.

While it should not be difficult to meet the above criteria, there are some aspects of documenting a consultation that deserve special attention. First, it is important to state that the consultation was performed intraoperatively to explain the "unusual" aspects of the case. If the patient could not furnish the history, the record should explain where the history was obtained—either from the medical record or from the other surgeon. If the consulting surgeon cannot obtain as complete a history as he or she would like, that should be explained. Although the two surgeons will actually be discussing the findings of the consultation, it is still important that the recommendations of the consultant (the second surgeon) be documented in the medical record.

Selecting the level of service is the most complicated aspect of reporting an intraoperative consultation. The E/M codes assume a "conventional" examination was performed, but in the typical intraoperative consultation, the patient has been opened or an endoscope has been placed. Therefore, the consultant must adapt the content of the physical examination portion of the consultation to fit the unique circumstances of an intraoperative consultation. The consultation would be reported with a modifier -57 on the consultation code to indicate the decision to have surgery was made during that encounter.

Once these criteria have been met and the procedure has been carefully documented, it is legitimate for the surgeon to charge for an intraoperative consultation and expect appropriate reimbursement for his expertise for the consult in addition to the operative service. For additional consultation rules, please refer to the "So-

cioeconomic tips of the month" in the October 1999 *Bulletin* (84(10):38,42), which addressed Medicare's clarification of the consultation rules. 

References

1. American Medical Association: *Frequently asked questions about CPT Coding, CPT Companion*. Chicago, IL: AMA, 1998. p. 158.
2. American Medical Association: Coding communication: Global surgical package. *CPT Assistant* (expanded issue), 8(11):5-9, 1998.

"Socioeconomic tips of the month" responds to questions from Fellows and their staffs, and provides useful tips for surgical practices. Developed by College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics 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.