UCLA Health System

Compliance Department

SURGERY AND SURGICAL MODIFIERS

11/2010

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Surgical Care Presence Requirements

- In order to bill for surgical services, teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure. If not immediately available, he/she must arrange for another qualified surgeon to assist, if needed.
- Fellows covered under Medicare GME payments are classified as residents and are not considered a “qualified surgeon” for immediate availability coverage.
- Clinical evaluation of adequate surgical coverage may not meet Medicare billing criteria.

Implications for Surgical Care

- **Minor Surgery**: For procedures that take only a few minutes (5 minutes or less) and involve little decision making once the need for the operation is determined, the teaching physician must be present for the entire procedure in order to bill for the procedure.

- **Endoscopy Procedures**: In order to bill, teaching physician must be present during the entire viewing. Entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing through a monitor in another room does not meet the TP presence requirements. (clarifies that rule excludes endoscopic surgery that follows the surgery section rules)

- **Single Surgery**: Teaching physician is present for entire surgery, documentation of presence may be documented by physician, resident or nurse.

Implications for Surgical Care (continued)

- **Two overlapping Surgeries**: Teaching physician must be present during critical/key portions of both surgeries which cannot take place at the same time. (*no change*)
  - Teaching physician must personally document in the medical record that he/she was physically present during the critical/key portions of both procedures. (clarification)
  - Teaching physician must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise. (clarification)
- **Three concurrent surgeries**: not payable under Medicare guidelines.

Modifier 57
Decision to Perform Surgery

- Append a modifier 57 to an E&M code when the physician evaluate the patient, and during the evaluation determines that a major surgical procedure needs to be done. Major is defined as a procedure with a 90-day follow-up care. This is not the same history and exam that a physician would do for the pre-op portion of the surgical package.

Modifier 54
Surgical Care Only

- Global surgical services include pre-, intra-, and post-operative services. If the primary surgeon performs only the surgery, Modifier 54 must be used to indicate that the primary surgeon performed no post-operative services, and the global surgical fee will be reduced to reflect the services performed.

Modifier 54
Surgical Care Only
(continued)

- While the patient is in-house. Medicare requires the primary surgeon at a Teaching Hospital to provide the key and critical portion of the post-operative service, which is at least one day of the hospital stay.

- Medi-Cal requires daily post-operative visits by the primary surgeon during the patient's hospital stay.

Modifier 82
Assistant at Surgery

- Generally, no payment is made for assistants at surgery in a teaching hospital that has a training program related to the medical specialty required for the surgical procedures and a qualified resident available to perform the services. However, Medicare allows assistants at surgery to bill if the services meet one of the following conditions:
  - Exceptional medical circumstances, for example an emergency, life threatening situation that requires immediate treatment.
  - A team of physicians is needed to perform complex medical procedures.

Modifier 82
Assistant at Surgery
(continued)

- Services constitute concurrent medical care relating to a medical condition that requires the presence of, and active care by, a physician of another specialty during surgery.
- Services are furnished by a physician who has an across-the-board policy of not involving residents in operative care, including pre- and post-operative care.

Modifier 82
Assistant at Surgery
(continued)

- If there is no qualified resident available to perform services, the assistant at surgery may bill if a "certification of unavailability of qualified resident" form is filed. The form may be an attachment to the claim or preprinted on the CMS 1500-Form. The certificate must state:

  I understand that §1842(b)(7)(D) of the Social Security Act generally prohibits Medicare Part B reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available. I certify that the services for which payment is claimed were medically necessary, and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by Medicare carrier.

Procedures

- Teaching physician must be present during critical and key portions & immediately available throughout
    - Surgical procedures
    - Endoscopic operations
- Teaching physician decides what portions are key
- If present entire time, resident's note (op report) can attest. However, both resident and teaching physician must sign the op report.
- If present for key portions only, teaching physician must document extent of involvement. Teaching physician must add an addendum to the resident's op report.

Procedures
(continued)

- Two overlapping surgeries
  - Key portions must happen at different times
  - Must be available to return to either
- Minor procedures of <5 minutes
  - Must be present the entire time
- Endoscopies (other than surgical operations)
  - TP must be present for entire viewing including insertion and removal

Modifier 25

- Append a modifier 25 to an E&M code if a significant, separately identifiable E&M service is performed by the same physician on the same day of a procedure or other service.
- The patient's condition must require E&M services above and beyond what would normally be performed in the provision of the procedure.
- The necessity for the E&M service may be prompted by the same diagnosis as the procedure.
- A new patient E&M service is considered separate from the same day surgery or procedure—no 25 modifier needed.

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Modifier 25
(continued)

- For an established patient, if the E&M service resulted in the initial decision to perform a minor procedure (0-10 days global period) on the same day and medical necessity indicates an E&M service beyond what is considered normal protocol for the procedure, the 25 modifier is appropriate.
- To determine the correct level of E&M service to submit, identify services unrelated to the procedure and use as E&M elements.
- Clearly mark the encounter form to indicate that a 25 modifier should be attached to the E&M.

Radiology/Diagnostic Tests

When the resident performs and dictates the interpretation,

- The teaching physician must personally review the test and the resident's interpretation.

- The teaching physician must document in a personal note that he/she reviewed the test and the resident's note and either agrees with it or edits the findings; co-signature is insufficient.

Impact of Changes/Summary

- Revised teaching physician rules do not eliminate the need for good documentation to facilitate patient care.
- Greater consideration will be made in scheduling of surgical cases.
- Examples provided in the scenarios are minimally acceptable documentation and may not be suited to your clinical situation.
- Physical presence/personal involvement is still needed to substantiate a billable claim.

Resources

- UCLA Compliance Office
  - Marti Arvin, Chief Compliance Officer (310) 794-6763
- Confidential Hotline 1-800 296-7188
- UCLA Compliance Website http://www.mednet.ucla.edu/compliance/.

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