SURGERY GUIDELINES

Information regarding publications incorporated by reference is found in the Introduction Section of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for surgical services. To the extent that a conflict may exist between CMS, an incorporated portion of the CPT®, and a code, guideline, identifier, or modifier unique to Arizona, then the Arizona code, guideline, identifier, or modifier shall control. Codes that are unique to Arizona are preceded by an AZ identifier and numbered in the following format: AZxxx.

A. MATERIALS AND SUPPLIES: A healthcare provider may charge for materials and supplies as described in the HCPCS Section of this Fee Schedule.

B. MULTIPLE PROCEDURES: It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes.

C. SPECIAL REPORT: A typical request for more detailed information from an insurance carrier regarding a billing does not constitute a "special report", which is defined in the CPT® book.

D. MODIFIERS: Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code, which may be reported in either of two ways. The modifier may be reported by a two-digit number placed after the usual procedure number from which it is separated by a hyphen. Or the modifier may be reported by a separate five-digit code that is used in addition to the procedure code. If more than one modifier is used, the "Multiple Modifiers" code placed first after the procedure code indicates that one or more additional modifier codes will follow.

   Modifiers either unique to Arizona or containing explanatory language specific to Arizona are as follows:

   22 Increased Procedural Services: Use of this modifier will result in a twenty-five percent (25%) increase in the listed value for the listed procedure.

   25 Separately Identifiable Evaluation and Management Service by the same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT® code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). As such, different diagnoses are not required for reporting of the E/M services on the same date. The circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

   47 Anesthesia by Surgeon: Used to report anesthesia by the attending or assistant surgeon (does not include local anesthesia). Reimbursement shall be fifty percent (50%) of the base unit as indicated in the Anesthesia section of the Fee Schedule. This modifier shall be allowed no more than once per surgical encounter.

50 Bilateral Procedure: Unless otherwise identified in the listings, when bilateral procedures which add significant time or complexity to patient care are provided at the same operative session, identify and value the first or major procedure as listed. Identify the secondary or lesser procedure(s) by adding modifier 50 to the usual procedure number(s) and value at fifty percent (50%) of the listed value(s). If, however, the procedures are independently complex and involve different parts of the body, including digits, the bilateral procedure rule would not apply. In such cases, independent procedures would be billed at one hundred percent (100%) of their listed value with modifier 51.

51 Multiple Procedures: When multiple procedures are performed during the same operative session*, the procedures should be valued at the appropriate percent of its listed value, as shown below:

100% (full value) for the first or major procedure 50% for the second and multiple procedure(s) sixth and subsequent procedures – by report.

*Multiple Procedure Guidelines do not apply to codes specifically identified as "Add-on/Additional Procedures, Global indicator ZZZ."

The major or primary procedure is defined as the procedure with the highest value and is the code that determines the follow-up days when a surgery has multiple procedures. The second procedure is the procedure with the next highest value, the third the next highest value, and so on. If, however, the procedures are independently complex such as digits, tendons, nerves, or artery repair, the multiple procedure rule would not apply. In such cases, independent procedures would be billed at one hundred percent (100%) of their listed value.

When performing multiple procedures with different global period values during the same operative session, the global period value for the session is the largest global period value.

57 Decision for Surgery: An Evaluation and Management (E/M) service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

Note: If an epidural or peripheral nerve block injection (62320-62327 or 64400-64530) for postoperative pain management is reported separately on the same date of service as an anesthesia 0XXXX code, **modifier 59** shall be appended to the epidural or peripheral nerve block injection code (62320-62327 or 64400-64530) to indicate that it was administered for postoperative pain management. An epidural or peripheral nerve block injection

(62320-62327or 64400-64530) for postoperative pain management in patients receiving general anesthesia, spinal (subarachnoid injection) anesthesia, or postoperative pain management in patients receiving general anesthesia, spinal (subarachnoid injection) anesthesia, or regional anesthesia by epidural injection as described above may be administered preoperatively, intraoperatively, or postoperatively.

62 Two (2) Surgeons: By prior agreement, the total value of services performed by two (2) surgeons working together as primary surgeons may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. If no apportionment is listed, the fee should be split evenly between the co-surgeons. The total value may be increased by twenty-five percent (25%) in lieu of the usual assistant's charge. Under these circumstances, the services of each surgeon should be identified by adding this modifier 62 to the joint procedure number(s) and valued as agreed upon. (Usual charges for surgical assistance may be warranted if still another physician is required as part of the surgical team.) The value of the procedure should be one hundred and twenty-five percent (125%) of the customary value listed. Payment of one hundred and twenty-five percent (125%) of the maximum allowable would be divided between the participating surgeons.

Two (2) Surgeons – When two (2) surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on codes(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may be reported with modifier 62 added.

Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80, 81, or 82 added, as appropriate.

80 Assistant Surgeon: These services are valued at twenty percent (20%) of the listed value of the surgical procedure(s).

81 Minimum Assistant Surgeon: These services are valued at sixteen percent (16%) of the listed value of the surgical procedure(s).

82 Assistant Surgeon (when qualified resident surgeon not available): These services are valued at sixteen percent (16%) of the listed value of the surgical procedure(s).

AS Use the modifier AS for assistant at surgery services when services are provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS). These services are valued at fourteen percent (14%) of the listed value of the surgical procedure(s). No further adjustment for mid-level medical providers as mentioned in section C of the Introduction shall be applied.

Note: A Medical Doctor or Doctor of Osteopathic Medicine should not submit the AS modifier. This modifier is only valid for use by a PA, NP, and CNS when billing under their own provider number.