## SURGERY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2017 Editions of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule *CPT*® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT*®-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx.

The Commission has also adopted by reference: 1) The most recent edition of *Complete Global Service Data for Orthopaedic Surgery*, American Academy of Orthopedic Surgeons; 2) The *1995 and 1997 Documentation Guidelines for Evaluation and Management Services*, Centers for Medicare and Medicaid Services (CMS); 3) The *National Correct Coding Initiative Edits*, CMS; and, 4) Physicians as Assistants at Surgery Update 2016. Additionally, the RBRVS-based fee schedule adopts surgical global periods published by CMS, replacing those published by Optum. Additional information regarding publications adopted by reference is found in the Introduction 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 adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

A. MATERIALS AND SUPPLIES: A physician may charge for materials and supplies as described in subsection (I)(4) of the Introduction Section of the Physician's Fee Schedule (page 10).

B. MULTIPLE PROCEDURES: It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. However, the primary procedure code is the code that determines the follow-up days when a surgery has multiple procedures.

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:

Δ-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.

Δ-47 Anesthesia by Surgeon: The value shall be fifty percent (50%) of the calculated American Society of Anesthesiologists Relative Value Guide value.

Δ-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 this 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.

Δ-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.

Δ-62 Two Surgeons: By prior agreement, the total value of services performed by two 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 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 125 percent of the customary value listed. Payment of 125% of the maximum allowable would be divided between the participating surgeons.

Two Surgeons – When 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 or modifier 82 added, as appropriate.

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

– OR –

Δ-81 Minimum Assistant Surgeons: These services are valued at ten percent (10%) of the listed value of the surgical procedure(s).