



An Independent Licensee of the Blue Cross and
Blue Shield Association

General Surgery

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January 2012

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Wellmark Practitioner Guide

Preface

The *Wellmark Provider Guide* and specialty guides are billing resources for providers doing business with Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota. The guides are referenced in your provider agreement, and include information that applies to all benefit plans in Iowa and South Dakota unless specified within the text.

Explanation of Terminology

Wellmark	Throughout the guides, the term Wellmark indicates Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota.
Member	Individuals with health coverage through Wellmark are referred to as members.

Provider Guide Updates

Wellmark's provider guides are continually updated to bring you the most current information. The following items identify when the guide or section was last changed.

- The most current date is printed on the front cover and inside pages. The date of the version replaced is also printed on the front cover.
- A *Summary of Changes* page lists all the substantial changes made in the most current update. The page(s) affected and a brief explanation of the change is linked from the *Summary of Changes* page to the change within the document.
- Changed text and most links appear in blue type.

How to Order Paper Copies of Provider Guides

We invite you to print Wellmark's provider guides from the website. However, if you prefer to order a paper copy, simply complete a Provider Forms Order (IA: B-0002; SD: B-3001) found on

[Wellmark.com > Provider > Communication & Resources > Forms](#), or in the Member and Service Information section of the *Wellmark Provider Guide*. If you do not have a forms order blank, contact a Provider/Customer Service representative for assistance. We will inform you of guide updates in the *Blue Ink* newsletter or on the Provider page of our website.

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General Surgery Section - Wellmark Practitioner Guide January 2012 Summary of Changes

Page 1: Wellmark processes claims using RVUs and/or indicators specified in the Medicare Physician Fee Schedule (MPFS), assigning its own RVUs/indicators for certain services where none have been assigned by CMS.

Page 7: Codes on the Medicare Physician Fee Schedule not assigned a Multiple Procedure indicator by CMS will be assigned one by Wellmark.

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I Introduction

- The *General Surgery* section explains Wellmark's billing guidelines for:
- surgical procedures,
 - pre- and postoperative care,
 - multiple and bilateral surgeries, and
 - the appropriate use of surgical modifiers.

Scope Information in this guide applies to networks and products offered or administered by Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Blue Cross and Blue Shield of South Dakota, and Wellmark Health Plan of Iowa, Inc. The guidelines may also apply to Select First, but as guidelines will vary, please check Select First coverage at <http://www.firstadministrators.com/> or call the phone number on the back of the member's ID card for details.

II Billing Guidelines for Surgical Procedures

- Wellmark covers a surgical procedure when it is:
- a covered service under the member's contract
 - medically necessary
 - in compliance with Wellmark's Coding and Payment Policies

Wellmark's definition of medical necessity may be found in the [Claims Filing section](#) of the *Wellmark Provider Guide*.

To determine a member's benefits, on Wellmark.com, log in to Wellmark. Under *Provider Tools*, select *Check Patient Benefits*. You may also contact the appropriate provider service area listed on the back page of this guide.

Wellmark processes claims using RVUs and/or indicators specified in the Medicare Physician Fee Schedule (MPFS). The Resource-Based Relative Value Scale (RBRVS) for the MPFS, developed by the Centers for Medicare and Medicaid Services (CMS), is not a complete schedule. By law, Medicare cannot pay for certain services. These services are usually not assigned relative value units (RVUs) or indicators by CMS. Wellmark will assign to these codes RVUs and/or indicators that can be subject to a modification of the Wellmark MAF (Maximum Allowable Fee).

Additional coding and payment policies are available on Wellmark.com. Log in and under Payment Policies, select Payment Policies for Professional Claims (CMS-1500). The website contains multiple links to coding and payment policies.

To gain first-time access to our secure online tools, apply by selecting the [Register for Wellmark.com](#) link on our website's Provider page.

How to access a prior approval list

Services Recommended/Required for Prior Approval

There are some treatments, procedures, services or supplies we *recommend* receive prior approval for Wellmark and Federal Employee Program (FEP) members. A list of these services can be found at [Wellmark.com \(Provider > Medical Policies & Authorizations > Prior Approvals\)](#). A list of the services or procedures *requiring* prior approval for FEP members can also be found using this link.

The prior approval process enables practitioners and members to receive a medical necessity determination *before* services are provided. While a prior approval that meets medical necessity guidelines for FEP members is a guarantee of benefits, that is not the case for Wellmark members. Always verify a member's benefits prior to performing the procedure or service.

Document services provided in the member's medical record

All services provided by participating practitioners should be documented in the member's medical record. Nondocumented services should not be billed to Wellmark. See the Medical Records Documentation guidelines in the Health Management section of the *Wellmark Provider Guide*.

How to submit a prior approval

To submit a prior approval form for everything but the drug-related services:

- 1) Use our secure Web tools at [Wellmark.com > Provider > Medical Policies & Authorizations > Prior Approvals](#) or
- 2) Complete one of the following interactive forms available at [Wellmark.com > Provider > Forms](#), and fax it to our office:
 - Iowa**
 - [Prior Approval form \(P-4602\)](#)
 - South Dakota**
 - [Prior Approval form \(N-3614\)](#)
 - FEP (IA and SD)**
 - [FEP Prior Approval form \(P-4306\)](#)

Drug-related services

To submit a request before providing one of the drug-related services, complete the service's unique treatment form found by the name of the drug-related service on the prior approval list. Complete the request form and fax it to 866-884-4345, or call Wellmark's Pharmacy Department at 800-600-8065.

To access Wellmark's medical policies

Only submit a prior approval or treatment form for items included on the recommended and required lists. There are medical policies for all of the treatments, procedures, services or supplies on the prior approval list. To view Wellmark's medical policies, go to [Wellmark.com > Provider > Medical Policies & Authorizations](#).

Payment Policies

For information on how Wellmark determines payment policies, please refer to the "[Claims Filing](#)" section of the *Wellmark Provider Guide*.

Global Billing

Physicians who perform the surgery and furnish all of the usual pre- and postoperative work bill for the global package by entering the appropriate CPT^{®*} code *for the surgical procedure only*. Separate billing for visits or other services that are included in the global package is not allowed.

Physicians of the same specialty who bill under the same tax ID are considered to be the same physician, and services included in the global period of the global procedure would not be billed separately.

Components of a surgical procedure

Surgical procedures described in *CPT* normally include the following components, in addition to the surgery itself:

Global billing, surgical procedures

- preoperative visits: preoperative visits after the decision is made to operate, beginning with the day before the day of surgery for major procedures, and the day of surgery for minor procedures
- subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of the surgery (including history and physical)
- the preoperative history and physical (H&P), regardless of when it takes place (1 day, 3 days, or 2 weeks before the surgery), is not separately billable, as it is included in the surgical package
- intraoperative services: intraoperative services that are normally a usual and necessary part of a surgical procedure
- local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- evaluating the member in the post-anesthesia recovery area
- immediate postoperative care, including dictating operative notes, talking with the family and other physicians
- typical postoperative follow-up care
- postoperative visits: follow-up visits during the postoperative period of the surgery, related to recovery from the surgery
- postsurgical pain management by the surgeon
- pain pumps
- supplies, except for those identified as exclusions
- miscellaneous services: items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes
- complications following surgery: all additional medical or surgical services required of the surgeon during the postoperative period due to complications which do not require additional trips to the operating room
- writing orders

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How to complete the CMS-1500 when submitting a global bill

To bill the surgery and its components as a surgical package on the CMS-1500 or professional electronic claim:

- Submit the date of the surgery as the date of service in loop 2400 DTP03 where DTP01 =472 on the electronic claim or in the "From" and "To" fields (24A) on the CMS-1500.
- Combine the charges for the surgery and its components into a single fee and submit that charge in loop 2400 SV102 on the electronic claim or in field 24F on the CMS-1500.
- Submit "1" in the Units of Service field: loop 2400 SV104 on the electronic claim or field 24G on the CMS-1500.

Combining charges into a single fee and billing them under the primary procedure is called global billing.

Global Surgery Days for Pre- and/or Postoperative Care

To find Medicare's global surgery days online

Wellmark follows Medicare's guidelines for pre- and postoperative days for all surgeries, regardless of the place of service. To find the number of pre- and postoperative days Medicare considers part of the global surgical fee, refer to Medicare's Physician Fee Schedule at <http://www.cms.hhs.gov/PhysicianFeeSched/> (PFS Relative Value Files). Choose the link for "PFS Relative Value Files" in the left column, and then choose the appropriate year. Wellmark will assign global days to procedures that Medicare has not addressed.

Billing Preoperative Services

Modifier 57; decision for surgery

For major procedures (90-day global period), the surgeon's preoperative services the day before and the day of the procedure are included in the global period. The "decision for surgery" Evaluation and Management (E/M) code should be billed separately from the global fee using a 57* modifier.

For minor procedures (0 or 10-day global period), the decision to perform the minor procedure is typically done immediately before the service. It is considered a routine preoperative service, and an evaluation and management is *not* billed in addition to the procedure.

Modifier 25

Modifier 25 is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made. It is used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service identified with a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding modifier 25 to the appropriate level of evaluation and management service.

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54 modifier;
billing surgery only*

Surgical Care Only

If the *only* service a practitioner provides is the surgery, with pre-and/ or postoperative care provided by another practitioner, bill the surgical procedure code with a 54 modifier.

Postoperative Services

All postoperative services are included in the global period.

*Postoperative
services outside the
global period
55 modifier*

If the only service a practitioner provides is the postoperative care, with the surgery performed by another practitioner, bill the surgical procedure code with a 55 modifier and "1" unit of service, even when the member was seen multiple times. Enter the first date of service for postoperative care in loop 2400 DTP03 where DTP01 = 472 on the electronic claim, or in the "Dates of Service" field (24A) on the CMS-1500.

*One physician-
all care*

If one practitioner provides the entire postoperative care, submit the surgical procedure code, append the 55 modifier and indicate "1" unit of service, even when the care includes multiple visits.

Modifier 58

Modifier 58 was established to facilitate billing of staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.

The physician may need to indicate that the performance of a procedure or service during the postoperative period was:

- a. Planned prospectively or at the time of the original procedure;
- b. More extensive than the original procedure; or
- c. For therapy following a diagnostic surgical procedure.

These circumstances may be reported by adding modifier 58 to the staged procedure. A new postoperative period begins when the next procedure in the series is billed.

Modifier 79

Modifier 79 reports an unrelated procedure by the same physician during a postoperative period. The physician may need to indicate that the performance of a procedure or service during a postoperative period was unrelated to the original procedure.

A new postoperative period begins when the unrelated procedure is billed.

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Modifier 24 **Modifier 24*** reports an unrelated evaluation and management service by same physician during a postoperative period. The physician may need to indicate that an evaluation and management service was performed during the postoperative period of an unrelated procedure. This circumstance is reported by adding the modifier 24 to the appropriate level of evaluation and management service.

Services submitted with the 24 modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. An ICD-9-CM code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

Complications of Surgery

All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room are included in the global package.

78 modifier When the complication does require a trip to the operating room, submit procedure[s] with the 78 modifier, indicating an unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure, for a related procedure during the postoperative period.

Increased Procedural Services

22 modifier The 22 modifier appended to the surgery code indicates that the work required to provide a service was substantially greater than typically required. Always attach additional documentation (e.g., an operative report) to the claim that supports the need for the additional work when you submit this modifier. After Wellmark reviews the documentation submitted with the claim, increased payment beyond the usual amount for that procedure may be made if our review staff agrees that it is warranted.

Definition of increased services Each procedure has a range of difficulty—some may be easier, some more difficult. The surgeon is not expected to charge less for a case that is easy. Similarly, he/she is not expected to charge more when the procedure is more difficult, within reason, since both types of cases will "average out" over time as a surgeon performs many cases. Use the 22 modifier only when the procedure is *clearly* out of the range of ordinary difficulty for that type of procedure.

If additional documentation is not received when the 22 modifier is billed, we will use the Maximum Allowable Fee (MAF) to process the service. After the claim has been processed, if you feel additional payment is warranted, complete a [Provider Inquiry](#) form, attach supporting documentation, and submit it to the address given on the form.

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Multiple Procedures

51 modifier When multiple surgeries are performed on the same day by the same provider, enter the primary procedure on the first line of the claim and "1" in the Units of Service. Enter additional surgical procedure code(s) on separate lines, attach a 51* modifier, and enter "1" in each Unit of Service.

Below is an example of how to bill multiple surgeries.

	24. A. DATE(S) OF SERVICE					B. PLACE OF SERVICE	C. EMO.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS ON INTR.	H. SPEC. FEE/ Fee	I. ID. QUAL.	J. RENDERING PROVIDER ID #
	From MM DD YY	To MM DD YY	MM	DD	YY			CPT/HCPCS	MODIFIER							
1	04	06	XX	04	06	XX	1		11600				1		NP	
2	04	06	XX	04	06	XX	1		11420	51			1		NP	

Use this modifier only when procedures do not share inclusive elements.

Modifier 51 exemptions **Note: Appendix D** in the *CPT* book lists CPT add-on codes (+) that do not require a 51 modifier. **Appendix E** lists codes that are exempt from use of the 51 modifier.

How physician payment is determined for multiple surgeries To determine payment for multiple surgeries performed on the same day by practitioners who have the same tax ID and same specialty, Wellmark calculates the most complicated surgical procedure at 100 percent of the MAF for that service, and additional surgical procedures at 50 percent of the MAF, unless the procedures are incidental to the primary surgical procedure. Wellmark considers incidental surgeries part of the primary procedure.

Procedures included in the multiple surgery payment rules are listed on the National Physician Fee Schedule Relative Value File with a "2" or "3" in the Multiple Procedure field. This file is published by the Centers for Medicare and Medicaid Services (CMS) and can be accessed online at www.cms.hhs.gov/PhysicianFeeSched/. Codes on this schedule not assigned a Multiple Procedure indicator by CMS will be assigned one by Wellmark.

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59 modifier The 59* modifier indicates that a procedure is distinct or independent from other services performed on the same day and should be used with procedures that are not normally reported together. The 59 modifier may be appropriate under unique circumstances and should be used to represent a procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same physician. The patient's medical record must support use of the 59 modifier. Wellmark applies the multiple surgery reduction to procedures included in the multiple surgery payment rules. Refer to the previous page for more information on multiple surgery payment.

HCPCS G0289 **Knee Arthroscopic Services**
Wellmark pays HCPCS code G0289 for reporting procedures performed in different compartments of the same knee. G0289 is an add-on code to the knee arthroscopy code for the major procedure being performed, and should be reported once per extra compartment, even if chondroplasty, loose body removal, and foreign body removal are all performed. The code may be reported twice (or with a unit of two) if the physician performs these procedures in two compartments *in addition* to the compartment where the main procedure was performed.

G0289 Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee

Report G0289 only when the physician spends at least 15 minutes in the additional compartment performing the procedure. It should not be reported if the reason for performing the procedure is due to a problem caused by the arthroscopic procedure itself. This code is to be used when a procedure is performed in the lateral, medial, or patellar compartments in addition to the main procedure.

We will not pay for the following services when performed with other arthroscopic procedures on the same knee:

- 29874 Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)
- 29877 Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)

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<i>How physician payment is determined for multiple endoscopies</i>	<p>Multiple Endoscopies</p> <p>Wellmark follows Medicare's multiple endoscopy rules to determine pricing for multiple endoscopic procedures. Endoscopies may be related (e.g., two different upper gastrointestinal [GI] procedures), or unrelated (e.g., an upper and a lower GI endoscopy). For each family of endoscopies (i.e., upper or lower GI), CMS identifies a "base" endoscopy procedure considered to be a component of all other endoscopies within that family. When calculating payment for multiple endoscopies, deduct the RVU (Relative Value Unit) of the base endoscopy from the RVU of the related procedure.</p> <p>Procedures included in the multiple endoscopy rules are those on the National Physician Fee Schedule Relative Value File, which have a "3" in the Multiple Procedure field. This list is available at www.cms.hhs.gov/PhysicianFeeSched/.</p>
<i>Related endoscopies</i>	<p>When two or more related endoscopies (i.e., in the same family) are performed, the endoscopy with the highest RVU is allowed at 100 percent. The additional related endoscopies are priced by subtracting the base endoscopy RVU. The base procedure is not paid separately. Payment for the base procedure is included in the payment for the most expensive endoscopy.</p>
<i>Unrelated endoscopies</i>	<p>When the endoscopies are unrelated (not in the same family), multiple surgery rules apply.</p>
<i>Related and unrelated endoscopies performed on the same day</i>	<p>To calculate payment when related and unrelated endoscopies are performed on the same day, Wellmark applies the related endoscopy payment rules first. Then we follow multiple surgery rules for the remaining unrelated endoscopies.</p>

Bilateral Procedures

Bilateral procedures are defined as two surgical procedures that are mirror images of each other performed on both sides of the body at the same operative session. Wellmark follows Medicare's Bilateral Status indicators on the Relative Value Unit (RVU) file.

50 modifier Submit the procedure code once with a 50* modifier and one unit of service, as shown below:

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. PRIOR AUTH. #	I. EQ. QUAL.	J. RENDERING PROVIDER ID. #
	From	To	CPT/HCPCS		MODIFIER											
MM	DD	YY	MM	DD	YY											
1	07	15	XX	07	15	XX	22		27280	50			1		NPI	
2															NPI	

If the procedure code has "unilateral or bilateral" in its description (e.g., 63045–63048), do not bill the 50 modifier. The MAF for procedure codes with "unilateral or bilateral" in the description is based on the procedure being performed as bilateral.

Procedures that can be submitted with a 50 modifier are listed on the National Physician Fee Schedule Relative Value File with a "1" or "3" in the Bilateral Surgery field. This file is published by the Centers for Medicare and Medicaid Services (CMS) and can be accessed online at www.cms.hhs.gov/PhysicianFeeSched/.

Allowance for 50 modifier Wellmark allows up to 150 percent of the MAF when a surgical procedure is billed with a 50 modifier. An exception to this rule is when there are multiple surgeries in addition to the bilateral procedure.

Co-Surgeon Services

62 modifier The 62 modifier for co-surgeons is appropriate when two surgeons, usually of different specialties, participate as co-surgeons for a specific procedure. Each surgeon would have a distinct operative report documenting the portion of the surgery he or she performed. Wellmark follows the same guidelines for this modifier as Medicare.

Access Medicare's Physician Fee Schedule online To find out if Medicare approves co-surgeons for a procedure, call your local Medicare Part B Provider Service or visit the Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov/PhysicianFeeSched/.

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Wellmark uses Medicare's indicators in the Co-Surg column of the PFS Relative Value File to determine payment:

Indicator 0: Co-surgeons not permitted for this procedure

Indicator 1: Co-surgeons may be paid with documentation to establish the medical necessity of two surgeons for the procedure (include a distinct operative report from both co-surgeons)

Indicator 2: Co-surgeons permitted and no documentation is required if the two-specialty requirement is met

If two surgeons of different specialties did not participate as co-surgeons for a specific procedure, consider using an assistant surgeon modifier rather than 62.* If two surgeons perform two distinct surgeries, there is no need to submit an assistant surgeon or co-surgeon modifier.

Anatomical Modifiers

Use anatomical modifiers with procedures performed on eyelids, fingers and toes. For example, select an appropriate finger modifier when billing procedure code 26010. A list of these modifiers and their complete descriptions can be found in Appendix 2 of the *HCPCS* book.

<u>Modifiers</u>	<u>Description</u>
E1 – E4	Modifiers for eyelids
F1 – F9, FA	Modifiers for fingers (Phalanges and Metacarpals)
T1 – T9, TA	Modifiers for toes (Phalanges and Metatarsals)

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III. Billing Guidelines for Assistant Surgeons

Wellmark allows benefits for an assistant surgeon for all surgeries on Medicare's Assistant Surgeon list, plus CPT* procedure codes 15002 and 15003. Services of an assistant surgeon for other procedures, including knee arthroscopy, are not considered medically necessary under Wellmark's health plans.

How to access Medicare's Assistant Surgeon Fee Schedule online

Access the Assistant Surgeon list on Medicare's website at <http://www.cms.hhs.gov/PhysicianFeeSched/> (PFS Relative Value Files). Information in the file is posted chronologically by year. The most current information is usually the last entry posted within any given year. Select the file that is effective for the date of service. When assistant surgeon modifiers (AS, 80, 81, or 82) are submitted, Wellmark uses Medicare's indicators on the PFS Relative Value File to determine payment:

AS modifiers

Indicator 0: Assistant surgeon may be paid with documentation to support medical necessity

Indicator 1: Assistant surgeon may not be paid

Indicator 2: Assistant surgeon may be paid

Although a hospital may require an assistant to be present at every surgery because of malpractice liability, Wellmark considers benefits for an assistant surgeon only for the procedures on the list.

Include NPI of performing surgeon on the appropriate claim line

Because a surgeon cannot serve as his own assistant, Wellmark will deny assistant surgeon charges unless the individual NPI (National Provider Identifier) of the performing surgeon is identified on each claim line. The rest of the claim will process according to the member's benefits. This change affects claims beginning with date of service **February 1, 2012.**

Assistant-at-Surgery Modifiers

AS Modifier

Surgical assist by P.A., N.P., or C.N.S.

The AS modifier identifies assistant-at-surgery services provided by a physician assistant (P.A.), nurse practitioner (N.P.) or clinical nurse specialist (C.N.S.). Services provided by these practitioners must be: 1) within the scope of their license, 2) rendered as assistance to the operating surgeon in the performance of a covered procedure, and 3) documented in the operative report.

Wellmark uses Medicare's Assistant Surgeon indicators on the Physician Fee Schedule Relative Value File to process claims submitted with an AS modifier. To view the Physician Fee Schedule online, visit www.cms.hhs.gov/PhysicianFeeSched/.

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Assist by M.D. or D.O.

80* Modifier

Add an 80 modifier to the surgery code to indicate that an M.D. or D.O. performed assistant-at-surgery services. This modifier is not intended for use by non-licensed physicians or non-physicians in the operating room.

81 and 82 Modifiers

Though the 80 modifier is the most common modifier for an assistant-at-surgery services, the 81 modifier may apply when:

- the procedure requires the services of an M.D. or D.O. as an assistant surgeon, or
- the assistant-at-surgery is not present for the entire procedure.

Bill the 82 modifier for assistant-at-surgery services provided by an M.D./D.O. *only* when a qualified resident surgeon is not available.

To bill for assistant surgeon services provided by an M.D. or D.O., submit the 80, 81, or 82 modifier along with the surgical procedure code.

IV Surgical Modifiers that Affect Payment

The modifiers listed below affect payment and may be added to the surgical CPT code when applicable. Payment is based on the lesser of the maximum allowable fee (MAF) or the actual charge. Percentages may vary when billing services for patients with coverage by products such as Select First™. Call the number on the back of the member ID for details.

Modifier	Definition	Payment
50	Bilateral procedure (performed in same operative session)	150% of MAF; 75% if multiple surgery rules apply
51	Multiple procedures (same day or same operative session)	100% of MAF for first surgery; 50% of MAF for add'l surgeries
52	Reduced services	75% of MAF prior to 07/01/2010 50% of MAF effective 07/01/2010
53	Discontinued procedure	50% of MAF effective 07/01/2010 Exceptions, all dates of service: Procedure codes 45378, G0105,G0121. These procedures are processed as follows: • 28% of MAF–Facility setting • 34% of MAF–Nonfacility setting
54	Surgical care only	INTRA OP% on CMS's Physician Fee Schedule Relative Value File

Cont. next page

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Modifiers that affect payment, cont.

Modifier	Definition	Payment
55	Postoperative management only	POST OP% on CMS's Physician Fee Schedule Relative Value File
56	Preoperative management only	PRE OP% on CMS's Physician Fee Schedule Relative Value File
62	Co-surgeons	62.5% of MAF for each surgeon
63	Procedure performed on infants less than 4 kg	120% of MAF effective 07/01/2010
78*	Return to the operating room for a related procedure during a postoperative period	INTRA OP% on CMS's Physician Fee Schedule Relative Value File
80	Assistant surgeon	25% of surgeon's MAF prior to 07/01/2010 16% of surgeon's MAF effective 07/01/2010
81	Minimum assistant surgeon	25% of surgeon's MAF prior to 07/01/2010 16% of surgeon's MAF effective 07/01/2010
82	Assistant surgeon (when qualified resident surgeon not available)	25% of surgeon's MAF prior to 07/01/2010 16% of surgeon's MAF effective 07/01/2010
AS	Physician assistant, nurse practitioner, or clinical nurse specialist for assistant at surgery	21.25% of surgeon's MAF prior to 07/01/2010 13.6% of surgeon's MAF effective 07/01/2010

V Casting and Surgical Trays for Office Surgeries

Bill the following HCPCS codes for casting. Select the code most appropriate for the service provided in your office.

Q4001–Q4051

Wellmark includes the cost of a surgical tray in the MAF for the surgery. We do not pay for a surgery tray that is billed separately.

VI Summary

The purpose of this section is to help you correctly bill surgical services to Wellmark. If you have questions about claims or benefits, please contact the appropriate Provider/Customer Service department (see phone numbers on the last page of this section). You may also use Wellmark's online secure Web tools at Wellmark.com > Provider to check members' claims, benefits, and eligibility.

To gain first-time access to our secure online tools, apply by selecting the [Register for Wellmark.com](#) link on our website's Provider page.

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Iowa Service Contacts

Wellmark Blue Cross and Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.
Des Moines, IA 50306-9232\

Wellmark Blue Cross and Blue Shield of Iowa* Wellmark Health Plan of Iowa, Inc.*

Provider Service

..... 800-362-2218 or 515-376-4688

Federal Employee Program*

..... 800-532-1537 or 515-376-4784

Tyson Foods

..... 800-526-5710

Iowa Bankers *for benefit questions only*

..... 800-258-1415 (call 800-362-2218 for claims issues)

UI Care, UI GradCare, and UI Select

..... 800-355-2031

Ford Retirees

Physicians ... 800-344-8525; Facilities ... 800-249-5103

Admission Notification, Precertification, and Case Management

..... 800-552-3993

Network Engagement

.... 800-700-9137

Contact to discuss contracting opportunities in your area

Pregnancy Program*

..... 866-460-9742

Disease Management Program*

..... 866-816-5264

Network Administration*

.... 800-708-1342 or 515-376-5100

Providing information about:

*network participation provider number
address change application status
credentialing/recredentialing status
taxpayer identification number change*

BlueCard® Program*

Out-of-state members' claim status or payment information

..... 800-362-2218 or 515-376-4688

Out-of-state members' eligibility information

.... 800-676-2583

EC (Electronic Commerce) Solutions*

..... 800-407-0267

Providing electronic claims and reports information

Pharmacy Department

..... 800-600-8065

South Dakota Service Contacts

Wellmark Blue Cross and Blue Shield of South Dakota
Sioux Falls, SD 57104

Wellmark Blue Cross and Blue Shield of South Dakota*

Provider/Customer Service Center

..... 800-774-3892 or 605-373-7292

Federal Employee Program*

..... 800-532-1537

Tyson Foods

..... 800-526-5710

Admission Notification, Precertification, and Case Management

800-642-9273

Network Engagement

.... 800-700-9137

Contact to discuss contracting opportunities in your area

Pregnancy Program*

..... 866-460-9742

Disease Management Program*

..... 866-816-5264

Network Administration*

.... 800-708-1342

Providing information about

*network participation provider number
address change application status
taxpayer identification number change*

BlueCard® Program

Out-of-state members' claim status or payment information

..... 800-774-3892

EC (Electronic Commerce) Solutions*

..... 800-407-0267

Providing electronic claims and reports information

Pharmacy Department

..... 800-600-8065



An Independent Licensee of the Blue Cross and
Blue Shield Association

*You will find e-mail links to these areas from our website at Wellmark.com > *Contact Us (top right of page)*. Select For Providers and on the next screen, choose your state.