5221.4035 FEE ADJUSTMENTS FOR MEDICAL/SURGICAL SERVICES.

Subpart 1. **Definition of a global surgical package.** Coding and payment for all surgical procedures is based on a global surgical package as described in this part and part 5221.4020, subpart 2a, items O, P, Q, and R. Physicians are not paid separately for visits or other services that are included in the global package.

A. To determine the global period for surgeries with a 090 global period in column O, include the day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.

EXAMPLE: Date of surgery, September 10; preoperative period, September 9; last day of global period, December 9.

To determine the global period for procedures with a 010 global period in column O, count the day of surgery and the appropriate number of days immediately following the date of surgery.

EXAMPLE: Date of surgery, January 5; last day of global period, January 15.

The global period for procedures with a 000 global period include only the services provided on the day of surgery.

B. Columns P, Q, and R of the Medicare Relative Value tables incorporated by reference in part 5221.4005 designate the percentages of the global package assigned to preoperative services, intraoperative services, and postoperative services. These are used to determine the percent of the maximum fee, established by the formula in part 5221.4020, subpart 1b, that is paid to physicians providing one or more components of the global package.

EXAMPLE: For physicians who perform the surgery and furnish all of the usual preoperative, intraoperative, and postoperative work the maximum fee is 100 percent (the sum or the percentages in columns P, Q, and R) of the maximum fee established by the formula in part 5221.4020, subpart 1b, for the appropriate CPT code and any appropriate modifiers for the surgical procedure only. Payment for physicians who furnish less than the full global package is described in subpart 4.

Other subparts may affect coding and payment for services for which a global period applies. Subpart 2 further defines services included in the global surgical package. Subpart 3 further defines services not included in the global surgical package. Subpart 4 governs coding and payment adjustment for physicians furnishing less than the full global package. Subpart 5 specifies additional coding and payment requirements for multiple surgeries. Subpart 6 specifies additional coding and payment requirements for bilateral procedures. Subpart 7 specifies additional coding and payment requirements for assistant-at-surgery. Subpart 8 specifies additional coding and payment requirements for cosurgeons. Subpart 9 specifies additional coding and payment requirements for team surgery.

Subp. 2. **Components of a global surgical package.** The global surgical package includes coding and payment instructions for the following services related to the surgery when furnished by the physician who performs the surgery. The services included in the global surgical package may be furnished in any setting, for example, in hospitals, ambulatory surgical centers, outpatient hospital surgical centers, and physicians' offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, certain critical care services identified by CPT codes 99291 and 99292 are payable separately as specified in subpart 3, item L. Included in the global surgical package are:

A. preoperative visits as follows:

(1) preoperative visits beginning with the day before the day of surgery for procedures with a global period of 090 days except that the evaluation and management service to determine the need for surgery is separately coded and paid in accordance with subpart 3, item A, subitem (1), even if the evaluation and management service is the day before or the day of surgery; and

(2) preoperative visits the day of surgery for procedures with a global period of 000 or 010 days unless a significant separately identifiable evaluation and management service is performed as described in subpart 3, item A, subitem (2);

B. intraoperative services which include services that are normally a usual and necessary part of a surgical procedure;

C. 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. Subpart 3, item G, governs services for postoperative complications which require a return trip to the operating room;

D. postoperative visits which include follow-up visits during the global period of the surgery that are related to recovery from the surgery;

E. postsurgical pain management by the surgeon;

F. supplies, except for those noted in subpart 3, item I; and

G. miscellaneous services 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.

Subp. 3. **Services not included in global surgical package.** The services listed in items A to O are not included in the global surgical package. These services may be

coded and paid for separately. Physicians must use appropriate modifiers as set forth in this subpart.

A. The initial consultation or evaluation of the problem by the surgeon to determine the need for a surgical procedure is coded and paid as specified in subitems (1) and (2):

(1) for services with a global period of 090 days, a separate payment is allowed for the appropriate level of evaluation and management service. This circumstance must be coded by adding CPT modifier 57 to the appropriate level of evaluation and management service; or

(2) for services with a global period of 000 or 010, and endoscopies, the initial consultation or evaluation services by the same physician on the same day as the procedure, are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, an evaluation and management service on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Payment for an evaluation and management service is not appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status. The physician must document in the medical record that 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 must be coded by adding CPT modifier 25 to the appropriate level of evaluation and management service.

B. Services of other physicians are not included in the global surgical package and are separately coded and paid as follows:

(1) preoperative physical examination and postdischarge services of a physician other than the surgeon are coded by the appropriate evaluation and management code and are paid separately. No modifiers are necessary;

(2) physicians who provide follow-up services for procedures with a global period of 000 or 010 that were initially performed in emergency departments may charge the appropriate level of office visit code and are paid separately. The physician who performs the emergency room service codes for the surgical procedure without a modifier;

(3) if the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician codes the appropriate evaluation and management service and is paid separately. No modifiers are necessary. An example is a cardiologist who manages underlying cardiovascular conditions of a patient; and

(4) where the surgeon and another physician or physicians agree to transfer care otherwise included in the global period, coding and payment are governed by subpart 4.

C. Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery, are not included in the global surgical package and are separately payable. Physicians must use the following modifiers if appropriate:

(1) CPT modifier 79 identifies an unrelated procedure by the same physician during a postoperative period. The physician must document that the performance of a procedure during a postoperative period was unrelated to the original procedure; and

(2) CPT modifier 24 identifies an unrelated evaluation and management service by the same physician during a postoperative period. This circumstance must be coded by adding CPT modifier 24 to the appropriate level of evaluation and management service. The physician must document that an evaluation and management service was performed during the postoperative period of an unrelated procedure. An ICD-9-CM code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

D. Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery is not included in the global surgical package and is separately payable. Complications from the surgical procedure are governed by item G and subpart 2, item C.

E. Diagnostic tests and procedures, including diagnostic radiological procedures and diagnostic biopsies, are not included in the global surgical package and are separately coded and payable. If a diagnostic biopsy with a ten-day global period precedes a major surgery on the same day or in the ten-day period, the major surgery is payable separately.

F. Clearly distinct surgical procedures during the postoperative period which are not reoperations for complications (reoperations for complications are governed by item G) are not included in the global surgical package and are separately payable. This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy, codes 61533, 61534-61536, 61539, 61541, and 61543, which may be performed in succession within 90 days of each other.

CPT modifier 58 must be used to code for staged or related surgical procedures done during the global period of the first procedure. The global period for the staged or subsequent procedures is separate from the global period for the proceeding procedure.

G. Treatment for postoperative complications which requires a return trip to the operating room is not included in the global surgical package and is separately coded and paid as specified in this item. This additional procedure is referred to as a reoperation.

"Operating room," for this purpose, is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. Operating room includes a cardiac catheterization suite, laser suite, and endoscopy suite. It does not include a patient's room, minor treatment room, recovery room, or intensive care unit, unless the patient's condition was so critical there would be insufficient time for transportation to an operating room.

(1) When coding for treatment for postoperative complications for services with a global period of 090 or 010 days which requires a return trip to the operating room, as defined in this item, physicians must code the CPT code that describes the procedures performed during the return trip as follows:

(a) Some reoperations have been assigned separate, distinct reoperation CPT procedure codes and RVUs. The maximum fee for these procedures is calculated using the RVUs for the coded reoperation and the formula in part 5221.4020.

(b) Reoperations that have not been assigned separate, distinct reoperation CPT codes must be identified on the bill with the CPT procedure code that describes the procedure or treatment for the complication plus CPT modifier 78 which indicates a return to the operating room for a related procedure during the global period. The CPT procedure code may be the one used for the original procedure when the identical procedure is repeated or another CPT procedure code which describes the actual procedure or service performed.

The maximum fee for a reoperation procedure without a separate distinct reoperation CPT code is the maximum fee established by the formula in part 5221.4020, subpart 1b, multiplied by the intraoperative percentage listed in column Q.

(c) When no CPT code exists to describe the treatment for complications, use an unlisted surgical procedure code plus CPT modifier 78 which indicates a return to the operating room for a related procedure during the global period. The maximum fee for the reoperation is the maximum fee for the original procedure established by the formula in part 5221.4020, subpart 1b, multiplied by 50 percent of the intraoperative percent listed in column Q.

(2) When coding for treatment for postoperative complications for a procedure with a 000 global period, physicians must use CPT modifier 78 which indicates a return trip to the operating room for a related procedure during the postoperative global period. The full value for the repeat procedure is paid according to the formula in part 5221.4020.

(3) If additional procedures are performed during the same operative session as the original surgery to treat complications which occurred during the original surgery, the additional procedures are coded and paid as multiple surgeries as specified in subpart 5. Only surgeries that require a return to the operating room due to complications from the original surgery are coded and paid as specified in subitems (1) and (2).

(4) If the patient is returned to the operating room after the initial operative session and during the postoperative global surgery period of the original surgery, for one or more additional procedures as a result of complications from the original surgery, each procedure required to treat the complications from the original surgery is paid as specified in subitem (1) or (2).

The multiple surgery rules under subpart 5 do not also apply. The original operation session and the reoperation session are separate and distinct surgical sessions. The reoperation is not considered a multiple surgery, as described in subpart 5, of the original operation. If during the reoperation session multiple surgeries are performed, the additional surgeries are not governed by the multiple surgery payment rules in subpart 5 but are governed by subitems (1) and (2).

(5) If the patient is returned to the operating room during the postoperative global surgery period of the original surgery, not on the same day of the original surgery, for bilateral procedures that are required as a result of complications from the original surgery, subitems (1) to (4) apply. The bilateral rules in subpart 6 and part 5221.4020, subpart 2a, item T, do not apply.

H. If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is coded and paid separately.

I. Surgical trays are not paid separately. Payment for the surgical tray is included in the RVUs for the surgical procedure.

J. Splints, casting, and take-home supplies are coded and paid separately.

K. Immunosuppressive therapy for organ transplants is coded and paid separately.

L. Critical care services (CPT codes 99291 and 99292) unrelated to the surgery, where a seriously injured or burned patient is critically ill and requires constant attendance of the physician, provided during a global surgical period, are coded and paid separately.

M. Except as provided in part 5221.0410, subpart 7, item A, the physician may separately bill a reasonable amount for supplementary reports and services directly related to the employee's ability to return to work, fitness for job offers, and opinions as to whether or not the condition was related to a work-related injury. Coding and payment for these services is governed by parts 5221.0410, subpart 7; 5221.0420, subpart 3; and 5221.0500, subpart 2.

N. The global surgical package does not apply, and separate coding and payment is allowed, for an initial service that meets both of the conditions in subitems (1) and (2):

(1) the service is for initial care only to afford comfort to a patient or to stabilize or protect a fracture, dislocation, or other injury; and

(2) subsequent restorative treatment, such as surgical repair or reduction of a fracture or joint dislocation, is expected to be performed by a physician other than the physician rendering the initial care only.

O. Surgeries for which services performed are significantly greater or more complex than usually required must be coded with CPT modifier 22 added to the CPT code for the procedure. Additional requirements for use of this modifier are as follows:

(1) This modifier may only be used where circumstances create a more complex procedure such as congenital or developmental disorders of the anatomy, multiple fractures of the same long bone, coexisting disease, when there has been previous surgery on the same body part or where there is a significant amount of scar tissue.

(2) This modifier may only be reported with procedure codes that have a global period of 000, 010, or 090 days.

(3) Physicians must provide:

(a) a concise statement about how the service is significantly more complex than usually required; and

(b) an operative report with the claim.

(4) The maximum fee for a surgical procedure that has satisfied all of the requirements for use of CPT modifier 22 is up to 125 percent of the maximum fee calculated under part 5221.4020, subpart 1b, for that CPT code listed in subpart 2b.

(5) CPT modifier 22 is not used to report additional procedures that are performed during the same operative session as the original surgery to treat complications which occurred during the original surgery. Additional procedures to treat complications which occurred during surgery are governed by subpart 5.

Subp. 4. **Physicians furnishing less than full global package.** There are occasions when more than one physician provides services included in the global surgical package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the postoperative and postdischarge care is split between two or more physicians where the physicians agree on the transfer of care. Coding and payment requirements for physicians furnishing less than the full global package are:

A. When more than one physician furnishes services that are included in the global surgical package, the maximum fee for each physician is a percentage of the total

maximum fee established by the formula in part 5221.4020, subpart 1b, multiplied by the sum of the percentages in columns P, Q, and R for the type of operative service provided. For example, the maximum fee for a physician who performs the preoperative and postoperative services, but not the intraoperative service, would be as follows:

The maximum fee for the CPT code established by the formula in part 5221.4020, subpart 1b	*	(the percentage in column P plus the percentage in column R)

B. Where physicians agree on the transfer of care during the global period, they must add the appropriate CPT modifier to the surgical procedure code:

(1) CPT modifier 54 for surgical care only; or

(2) CPT modifier 55 for postoperative management only.

C. Physicians who share postoperative management with another physician must submit additional information showing when they assumed and relinquished responsibility for the postoperative care. If the physician who performed the surgery relinquishes care at the time of discharge, the physician need only show the date of surgery when billing with CPT modifier 54.

However, if the surgeon also cares for the patient for some period following discharge, the surgeon must show the date of surgery and the date on which postoperative care was relinquished to another physician. The physician providing the remaining postoperative care must show the date care was assumed.

D. If a surgeon performs a procedure with a global period of 010 or 090 days, and cares for the patient until time of discharge from a hospital or ambulatory surgical center, the maximum fee for this surgeon's services is:

The maximum fee for the CPT code established by the formula in part 5221.4020, subpart 1b	*	(the percentage in column P plus the percentage in column Q)

Modifier 54 is used to identify these services.

E. If a health care provider who did not perform the surgery assumes surgical follow-up care of a patient after discharge from the hospital or ambulatory surgical center, then the maximum fee for this practitioner's services is:

The maximum fee for the CPT code established by the formula in part 5221.4020, subpart 1b	*	(the percentage in column R)

CPT modifier 55 is used to identify these services.

F. If several health care providers furnish postoperative care, the maximum fee for the postoperative period is divided among the practitioners based on the number of days

for which each health care provider was primarily responsible for care of the patient. CPT modifier 55 (for postoperative management only) is used to identify postoperative services furnished by more than one provider.

G. If the providers have agreed to a payment distribution of the global fee that differs from the distributions set forth in items D to F, then payments will be made accordingly, if the agreed-upon distribution is documented and explained on the bill for the procedure and is not prohibited by Minnesota Statutes, section 147.091, subdivision 1, paragraph (p).

Subp. 5. **Coding and payment for multiple surgeries and procedures.** Part 5221.4020, subpart 2a, item S, and column S in the tables incorporated by reference in part 5221.4005, subpart 1, item A, describe codes subject to the multiple procedures payment restrictions. Multiple surgeries are separate surgeries performed by a single physician on the same patient at the same operative session or on the same day for which separate payment may be allowed.

A. The coding requirements in subitems (1) and (2) apply to multiple surgeries that have an indicator of 2 or 3 in column S by the same physician on the same day as specified in items D and E:

(1) the surgical procedure with the highest maximum fee calculated according to part 5221.4020, subpart 1b, is reported without the multiple procedures CPT modifier 51;

(2) the additional surgical procedures performed are reported with CPT modifier 51.

B. There may be instances in which two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day, for example, in some multiple trauma cases. When this occurs, CPT modifier 51 is not used and the multiple procedure payment reductions do not apply unless one of the surgeons individually performs multiple surgeries.

C. If any of the multiple surgeries are bilateral or cosurgeries, first determine the allowed amount for the procedure as specified in subpart 6 or 8, next rank this amount with the remaining procedures, and finally, apply the appropriate multiple surgery payment reductions as specified in items D and E.

D. For procedures with an indicator of 2 in column S, if the procedures are reported on the same day as another procedure with an indicator of 2, the maximum fee for the procedure with the highest amount calculated under part 5221.4020, subpart 1b, is paid at 100 percent of the amount calculated, and the maximum fee for each additional procedure with an indicator of 2 is paid at 50 percent of the amount calculated under part 5221.4020, subpart 1b.

E. For procedures with an indicator of 3 in column S, the multiple endoscopy payment rules apply if the procedure is billed with another endoscopy with the same base code. Column X lists the endoscopic base code for each code in column A with a multiple surgery indicator of 3. For purposes of this item, the term "endoscopy" also includes arthroscopy procedures. If an endoscopy procedure is performed on the same day as another endoscopy procedure within the same base code, the maximum fee for the procedure with the highest amount calculated under part 5221.4020, subpart 1b, is 100 percent of the amount calculated. The maximum fee for every other procedure with the same base code is reduced by the amount calculated under part 5221.4020, subpart 1b, for the endobase code in column X. No separate payment is made for the endobase procedure when other endoscopy procedures with the same base code are performed on the same day.

(1) For example, if column S has an indicator of 3 for multiple endoscopic procedures, and column X lists the endoscopic base code as 29805, with a maximum allowable fee of $400 calculated according to the formula in part 5221.4020, subpart 1b, the maximum amount payable would be as follows:

Procedures performed (code listed in column A)	Maximum fee under formula in part 5221.4020, subpart 1b	Maximum fee under part 5221.4035, subpart 5, item E	Description
29827	$950	$950	Pay 100 percent of the maximum fee for the procedure with the highest maximum fee under formula in part 5221.4020, subpart 1b
29828	$790	$390	Reduce the maximum fee by $400 (the maximum fee for endobase code 29805) $790 - $400 = $390
29823	$540	$140	Reduce the maximum fee by $400 (the maximum fee for endobase code 29805) $540 - $400 = $140
Total allowable payment:		$1480	

(2) For two unrelated series of endoscopy procedures, the endoscopy pricing rule is applied first to all codes with the same base code in column X. The multiple surgery pricing rule as depicted by indicator 2 is then applied as follows. The maximum fee for the codes in the series with the highest total amount calculated under this item is 100 percent

of the amount calculated. The maximum fee for codes in the series with the lower total amount calculated under this item is 50 percent of the amount calculated.

(3) Endoscopy procedures billed with other surgery procedures. All procedures subject to the multiple surgery pricing rule are ranked from highest to lowest to determine which codes, or groups of codes, are allowed at 100 percent or 50 percent of the their calculated maximum value. If two or more of the billed codes belong to the same endoscopy family, the endoscopy pricing rule is applied first, and the total value of the endoscopy series is used in the array.

F. For diagnostic imaging procedures with an indicator of 4 in column S, special rules for the technical component (TC) and professional component (PC) of diagnostic imaging procedures apply if the procedure is billed with another diagnostic imaging procedure with indicator 88 in column AB. If the procedure is furnished by the same provider, or different providers in the same group practice, to the same patient in the same session on the same day as another procedure with indicator 88, the procedures must be ranked according to the maximum fee for the technical component and professional component, calculated according to the formula in part 5221.4020, subpart 1b. The technical component with the highest maximum fee is paid at 100 percent, and the technical component of each subsequent procedure is paid at 50 percent. The professional component with the highest maximum fee is paid at 100 percent, and the professional component of each subsequent procedure is paid at 75 percent. For example:

	Unadjusted Maximum Fee, Procedure 1	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
PC	$68	$102	$152	$102 + (.75 x $68)
TC	$476	$340	$646	$476 + (.50 x $340)
Global	$544	$816	$799	$102 + (.75 x $68) + (.50 x $340)

G. For procedures with an indicator of 5 in column S that are not also listed in part 5221.4050, subpart 2d, or 5221.4060, subpart 2d, the following rules apply to establish the maximum fee according to the formula in part 5221.4020, subpart 1b:

(1) When more than one unit or procedure with an indicator of 5 is provided to the same patient on the same day, full payment is made for the unit or procedure with the highest practice expense (PE) RVU.

(2) For subsequent units and procedures furnished to the same patient on the same day in office settings and other noninstitutional settings, full payment is made for

the work and malpractice expense RVUs and 80 percent payment is made for the practice expense RVU.

(3) For subsequent units and procedures furnished to the same patient on the same day in institutional settings, full payment is made for the work and malpractice expense RVUs and 75 percent payment is made for the practice expense RVU.

(4) For therapy services furnished by a provider, a group practice, or incident to a provider's service, the reduction described under this subitem applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, such as physical therapy, occupational therapy, or speech-language pathology, and regardless of the type of provider or supplier.

(5) For example:

	Unadjusted Maximum Fee, Procedure 1 Unit 1	Unadjusted Maximum Fee, Procedure 1 Unit 2	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
Work	$7	$7	$11	$25	No reduction
PE	$10	$10	$8	$23.50	$10 + (.75 x $10) + (.75 x $8)
Mal-practice	$1	$1	$1	$3	No reduction
Total	$18	$18	$20	$51.50	$18 + ($7 + $1) + (.75 x $10) + ($11 + $1) + (.75 x $8)

H. For diagnostic cardiovascular services with an indicator of 6 in column S, the procedures must be ranked according to the maximum fee for the technical component (TC) calculated according to the formula in part 5221.4020, subpart 1b. Full payment is made for the TC service with the highest payment. Payment is made at 75 percent for subsequent TC services furnished by the same provider, or by multiple providers in the same group practice, to the same patient on the same day. There is no reduction for the professional component (26). For example:

	Unadjusted Maximum Fee, Code 78452	Unadjusted Maximum Fee, Code 93306	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
26	$77	$65	$142	No reduction

TC	$427	$148	$538	$427 + (.75 x $148)
Global	$504	$213	$680	$142 + $427 + (.75 x $148)

I. For diagnostic ophthalmology services with an indicator of 7 in column S, the procedures must be ranked according to the maximum fee for the technical component (TC) calculated according to the formula in part 5221.4020, subpart 1b. Full payment is made for the TC service with the highest payment. Payment is made at 80 percent for subsequent TC services furnished by the same provider, or by multiple providers in the same group practice, to the same patient on the same day. There is no reduction for the professional component (26). For example:

	Code 92235	Code 92250	Total Payment	Payment Calculation
26	$46	$23	$69	No reduction
TC	$92	$53	$134.40	$92 + (.80 x $53)
Global	$138	$76	$203.40	$69 + $92 + (.80 x $53)

J. For procedures with an indicator of 0 or 9, no payment rules for multiple or endoscopy procedures apply.

Subp. 6. **Coding and payment for bilateral surgeries and procedures.** Part 5221.4020, subpart 2a, item T, and column T in the tables incorporated by reference in part 5221.4005, subpart 1, describe codes subject to the bilateral procedures payment restrictions. Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.

A. For procedures with an indicator of 0, 3, or 9 in column T, no bilateral payment provisions apply.

For procedures with an indicator of 0, the 150 percent bilateral adjustment in item B is inappropriate because of physiology or anatomy or because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. If the procedure is reported with modifier 50, or with modifiers RT and LT, the maximum fee for both sides is the fee calculated according to part 5221.4020, subpart 1b, for a single code. If the provider or payer reassigns a correct code for a bilateral procedure the maximum fee is the amount calculated according to part 5221.4020, subpart 1b, for the correct code and corresponding indicator.

Services with an indicator of 3 are generally radiology procedures or other diagnostic tests that are not subject to bilateral payment adjustments. If the procedure is reported with modifier 50 or is reported for both sides on the same day by any other means, such as with

RT and LT modifiers or with a 2 in the units field, the maximum fee for each side is the amount calculated according to the formula in part 5221.4020, subpart 1b, for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the maximum fee for the bilateral procedure before applying any multiple procedure rules as specified in subpart 5, item C.

For procedures with an indicator of 9, the concept of bilateral surgeries does not apply.

B. For procedures with an indicator of 1 in column T, if the code is billed with modifier 50 or is reported twice on the same day by any other means, such as with RT and LT modifiers or with a 2 in the units field, the maximum fee is 150 percent of the amount calculated according to the formula in part 5221.4020, subpart 1b, for a single code. The bilateral adjustment is applied before any multiple procedure rules as specified in subpart 5, item C.

C. For procedures with an indicator of 2, no further bilateral adjustments apply because the RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier 50 or is reported twice on the same day by any other means, such as with RT and LT modifiers or with a 2 in the units field, the maximum fee for both sides is the amount calculated according to part 5221.4020, subpart 1b, for a single code.

Subp. 7. **Coding and payment for assistant-at-surgery.** Part 5221.4020, subpart 2a, item U, and column U in the tables incorporated by reference in part 5221.4005, subpart 1, describe codes subject to the assistant-at-surgery payment restrictions. An assistant-at-surgery must use the appropriate CPT or HCPCS modifier in accordance with their provider type. Payment for a physician assistant-at-surgery is not allowed when payment is made for cosurgeons or team surgeons for the same procedures. For procedures with an indicator of 0 (where medical necessity is established) or 2 in column U the maximum fee for an assistant-at-surgery is as follows:

A. For a physician who is an assistant-at-surgery, 16 percent of the global surgery fee is paid. This is paid in addition to the global fee paid to the surgeon.

B. If the assistant surgery service is performed by a provider who is not a physician, but who has advanced training to act as an assistant-at-surgery consistent with their scope of practice, 13.6 percent of the global surgery fee is paid. This is paid in addition to the global fee paid to the surgeon.

Subp. 8. **Coding and payment for cosurgeons.** Part 5221.4020, subpart 2a, item V, and column V in the tables incorporated by reference in part 5221.4005, subpart 1, describe codes subject to the cosurgeon's payment adjustments. Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex

nature of the procedures or the patient's condition. It is cosurgery if two surgeons, each in a different specialty, are required to perform a specific procedure, for example, heart transplant. Cosurgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, for example, bilateral knee replacement. In these cases, the additional physicians are not acting as assistants-at-surgery.

A. If cosurgeons are required to do a procedure, each surgeon codes for the procedure with CPT modifier 62 which indicate two surgeons.

B. For procedures with an indicator of 1, where necessity of cosurgeons is established, or 2 in column V, the amount paid for the procedure is 125 percent of the global fee, divided equally between the two surgeons. If the cosurgeons have agreed to a different payment distribution, payments will be made accordingly, if the agreed-upon distribution is documented and explained on the bill for the procedure, and is not prohibited by Minnesota Statutes, section 147.091, subdivision 1, paragraph (p).

C. For procedures with an indicator of 0 or 9 in column V, either cosurgeons are not allowed or the concept of cosurgery does not apply and cosurgery fee adjustments do not apply.

D. If surgeons of different specialties are each performing a distinctly different procedure with specific CPT codes, cosurgery fee adjustments do not apply even if the procedures are performed through the same incision. If one of the surgeons performs multiple procedures, the multiple procedure rules in subpart 5 apply to that surgeon's services.

Subp. 9. **Coding and payment for team surgery.** Part 5221.4020, subpart 2a, item W, and column W in the tables incorporated by reference in part 5221.4005, subpart 1, govern application of the team surgery concept.

A. If a team of surgeons, that is, more than two surgeons of different specialties, is required to perform a specific procedure, each surgeon bills for the procedure with the CPT modifier 66 which indicates a surgical team.

B. For procedures with an indicator of 1, where necessity of a team is established, or 2 in column W, the amount paid for the procedure is limited by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b.

C. For procedures with an indicator of 0 or 9 in column W, either team surgery is not allowed or the concept of team surgery does not apply.

Subp. 10. **Unbundling surgical services.** Where several component services which have different CPT codes may be described in one more comprehensive CPT code, only the single CPT code most accurately and comprehensively describing the procedure performed or service rendered may be reported. Intraoperative services, incidental surgeries, or components of more major surgeries are not separately billable or payable.

For example, an anterior arthrodesis of the lumbar spine using the anterior interbody technique may be performed by two surgeons. One of the surgeons may perform opening or the approach for the anterior arthrodesis while a different surgeon performs the arthrodesis. In this instance, the surgeons are acting as cosurgeons performing different components of a major surgery. The opening or approach is not a separately billable or payable procedure. Both surgeons must code this service using the anterior arthrodesis code and are paid for the procedure as cosurgeons as specified in subpart 8.

Statutory Authority: *MS s 14.38; 14.386; 14.388; 176.135; 176.1351; 176.136; 176.83*

History: *25 SR 1142; 35 SR 227; 38 SR 306*

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