

CHILDREN'S HOSPITAL LOS ANGELES MEDICAL GROUP
COMPLIANCE POLICY MANUAL

POLICY	Surgical Care Presence Requirements
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POLICY

In order to bill for surgical services¹, teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure. If not immediately available, he/she must arrange for another qualified surgeon to assist, if needed. Medicare classifies fellows that it covers under GME payments as residents and Medicare does not consider them to be “qualified surgeons” for immediate availability coverage. The operative report should indicate the actual surgeon as the “physician performing the procedure.” The report may list the resident or fellow the assistant surgeon, as appropriate.

DEFINITIONS

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

Major Surgery: Procedures that have a global billing period of 90 days. Medicare assigns global periods at the CPT code level. When a procedure is dangerous or complex, the teaching physician must be present during all critical portions of the procedure and must be immediately available to furnish assistance during the entire procedure.

***Key Portion:** The “key portion” of a surgical procedure to mean everything that takes place between opening and closing of the patient. However, sometimes the opening and/or closing of the patient may indeed be the “key portion” of the procedure. In these cases, the teaching physician must also be available at those times.

BILLING AND DOCUMENTATION REQUIREMENTS

In order to appropriately bill for surgical procedures that a resident performs or the teaching physician performs with residents, the teaching physician must:

- Be present during critical and key portions & immediately available throughout surgical operations and endoscopic procedures
- The teaching physician decides what portions of the operation or procedure are “key*”
- If present the entire time, the resident’s operative report can attest to the teaching physician’s presence.
 - Both the resident and the teaching physician must sign the operative report
- If the teaching physician is present for the key portions only, the teaching physician must document the extent of his/her involvement.
 - Teaching physician must add an addendum to the resident’s operative report.

¹ The term “surgery” and/or “operative note” include therapeutic and diagnostic *procedures* that require documentation to support the medical necessity and billing of the service. Examples include but are not limited to endoscopic, cardiovascular, neurologic, hematologic, and/or Integumentary *procedures*.

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Single Surgery: If teaching physician is present for entire surgery, the physician or resident may document the physician's presence.

Two overlapping Surgeries: Teaching physician must be present during critical/key portions of both surgeries, which cannot take place at the same time.

- Teaching physician must personally document in the medical record that he/she was physically present during the critical/key portions of both procedures.
- Teaching physician must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise.

Three concurrent surgeries: Are not payable under Medicare or Medi-Cal guidelines

Endoscopic Procedures: In order to bill, teaching physician must be present during the entire viewing. Entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing through a monitor in another room does not meet the teaching physician presence requirements.

Follow-up Inpatient Care for the Postoperative Patient: While the patient is in-house, Medicare and Medi-Cal require the primary surgeon to furnish postoperative care.

- Medi-Cal requires daily post-operative visits by the primary surgeon during the patient's hospital stay. Medi-Cal considers postoperative visits to be part of the surgical global package and not separately billable.
- Medicare requires that the primary surgeon at a teaching hospital provide the key and critical portion of the post-operative service, which is at least one day of the hospital stay.

STANDARD USAGE OF MODIFIERS IN SURGERY

In order to report surgical procedures completely and accurately, it is sometimes necessary to append modifiers, which "modify" the CPT code. These modifiers generally affect payment, so it is important that staff append them correctly.

Modifier -57: Decision for Surgery. Teaching physician and resident determine surgery is necessary at the time of an Evaluation and Management Service. Resident and teaching physician follow documentation rules for E/M services.

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

Modifier -54: Surgical Care Only

- If the primary surgeon performs only the surgery, staff must use Modifier -54 to indicate that the primary surgeon performed no post-operative services, and the carrier will reduce the global surgical fee to reflect the services

Modifier -80: This modifier should be reported to identify surgical assistant services performed in a non-teaching setting or in a teaching setting when a resident was available but the surgeon opted not to use the resident. In the latter case, the service is generally not covered by Medicare.

Non-Teaching Setting:

When the surgical services are performed in a non-teaching setting, report "Non-teaching" in the narrative section of an electronic claim submission, or in Block 24D for paper claims.

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Teaching Setting:

Assistant at Surgery. Payers reimburse assistants at surgery in a teaching hospital who have a training program related to the medical specialty required for the surgical procedures and a qualified resident is available to perform the services.

For Medicare patients only: Medicare does not allow payment for assistant at surgery when a qualified resident is available to perform that function. However, if there is no qualified resident available to perform services, the assistant at surgery may bill if he or she files a "certification of unavailability of qualified resident." The assistant may attach the form to the claim or preprint the Billing Claim Form CMS-1500. The certificate must state:

"I understand that § 1 842(b)(7)(D) of the Social Security Act generally prohibits Part B reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available. I certify that the services for which payment is claimed were medically necessary, and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by carrier."