SURGERY GUIDELINES

The general guidelines and modifiers found in the 2013 CPT®-4 were adopted by reference by the Industrial Commission and are applicable when utilizing Arizona's Physicians' Fee Schedule. The Surgery Guidelines adopted by reference may be found in the *Current Procedural Terminology®, Fourth Edition ("CPT® book")* published by the AMA. 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 the adopted portions of the CPT®-4 and a code or guideline unique to Arizona, the Arizona code or guideline shall control.

1. MATERIALS AND SUPPLIES: A physician may charge for materials and supplies as described in subsection (F)(4) of the Introduction Section of the Physician's Fee Schedule (page 12).

2. 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.

3. 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.

4. 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.

   The values for modifiers unique to Arizona are as follows:

   Δ-17 In-Office Surgical Procedures: For minor surgical procedures that are conducted in the office in lieu of an outpatient ambulatory care center, an add-on fee is permitted that would allow an additional fee of 25% of the surgical procedure, not to exceed $300, provided the following conditions are met: 1) The medical procedure is performed under local anesthesia where an Anesthesiologist and sophisticated monitoring devices are not necessary; and 2) The medical procedure is one that historically has been done in ambulatory out-patient service center. Costs associated with the use of equipment (such as sterilizers and surgical instruments), supplies

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and drugs associated with the surgical procedure and the use of the facility are included within this fee. It would not be appropriate to separately bill for the purchase of equipment, facility charges or supplies under code 99070. Additionally, procedures that have historically been done in a physician's office, including suturing lacerations or minor debridement of wounds, are not covered under this modifier.

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 at 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 procedure
25% for the third procedure
10% for the fourth procedure
5% for the fifth procedure
Over five procedures – by report

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.

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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. 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.)

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).

5. In the text of the Fee Schedule, we utilize * and ** to denote "add-on" codes and those codes that are exempt from the multiple procedure rule.

a. * Denotes Add-On Codes

(List separately in addition to code for primary procedure)

Note: This code is an add-on procedure and as such is valued appropriately. Multiple procedure guidelines for reduction of value are not applicable.

b. ** Denotes Codes Exempt from Modifier "-51"

Note: Multiple procedure guidelines for reduction of value are not applicable for this code.

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