

## Overlapping Surgical Cases

CMS has specific guidelines around two overlapping surgeries which VUMC follows. **If the provider has two surgeries overlapping you must be present for the critical or key portions of both operations.** The teaching provider must also indicate a statement that states he/she was there for those portions. If this does occur, the provider must note a covering surgeon who is readily available. Surgeon professional fees cannot be billed if there are three or more overlapping cases.

If you are listed as the covering surgeon, you have **48 hours** to complete the covering surgeon attestation. *You are not able to be the co-surgeon and covering surgeon in the same case.*

VUMC has created an internal house code, 00064, to use when there is a non-billable overlapping case, so the Section is able to track these occurrences.

Every Friday a report goes out to key players if the attestation or notation of a covering surgeon is missing. Your Chair and/or Administrative Officer will be in contact. These requests should also be in your VMG Coding Task.

The policies for both Peri-Operative Safety and VMG Coding Services Standard Operating policies can be found at:

<https://vanderbilt.policytech.com/dotNet/documents/?docid=10607> (Peri-Operative Services Policy)

<https://vanderbilt.policytech.com/dotNet/documents/?docid=27429> (VMG Coding Services Standard Operating Procedure)



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For More information and Questions email: [Chelsea.Provot@vumc.org](mailto:Chelsea.Provot@vumc.org)

# Query Response

When a patient is admitted to the hospital in a status of “Inpatient,” the payment is based on a DRG (Diagnostic Related Group), which is a patient classification system that standardizes prospective payments; for the Section, this is most based around procedures. More information around DRG(s) can be found [here](#).

Along with specificity of the procedure, the CHIMS team is looking for additional diagnoses affecting payment due to reflection of complexity, length of stay (LOS) prediction, risk of mortality (ROM), or severity of illness (SOI) scoring. Those implications are the drivers for the provider queries, not just gratuitous questions.

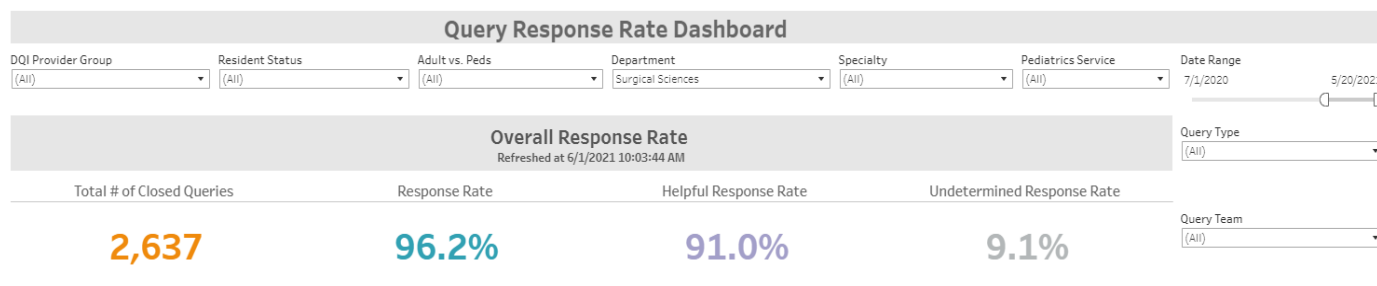
When you respond to a query, they are tracked as:

- Agreed and Documented
- Alternate Diagnosis
- Clinically Unable to Determine
- Recipient Agreed: documentation not updated
- Disagreed
- Auto Completed: non-codable



Each provider has a breakdown of helpful response rates and undetermined response rates. **Our goal is to avoid the response of “Undetermined” and provide a clear, concise answer.** We are reaching the goal of response rates, which is 95%.

Section of Surgical Science responses from July 1, 2020 through May 20, 2021:



Our monthly newsletter reviews conditions with a high number of undetermined responses. If you are having a higher undetermined rate than your peers, education will be provided in the coming months.

**Please remember a DRG classification relates to ALL Inpatient cases. Even if an elective operation, the CHIMS team is still looking for those chronic and acute conditions.**

**If you would like to review your query rates individually, please contact Chelsea Provot.**

## CME Credit Information

**Every month CME credit will be offered!**

We appreciate all your hard work with expanding your education around documentation. Simply follow the directions below.

Vanderbilt University Medical Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Vanderbilt University Medical Center designates this enduring material for a maximum of **0.5 AMA PRA Category 1 Credit(s)<sup>™</sup>**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

To claim credit for this activity, go to <https://vumc.cloud-cme.com/SurgicalNewsletterJune> and complete all content, including the required course evaluation. Once complete, credits will appear on your transcript and a course completion certificate will be available for download.

## Condition Corner

Malnutrition is an acute, subacute, or chronic state of nutrition which can be a combination of overnutrition or undernutrition which led to diminished function of the body.

**VUMC follows ASPEN criteria. The diagnosis can be confirmed by the dietician but must be noted in a provider (resident, attending, NP/PA) note – may be H&P, progress note, or discharge summary.**

For a patient to be diagnosed as malnourished, two of the six characteristics must be met:

- Energy Intake
- Interpretation of Weight Loss
- Body Fat
- Muscle Mass
- Fluid Accumulation
- Reduced Grip Strength

**Further references are available on page 4 of this newsletter**



**Table.** Academy of Nutrition and Dietetics (Academy)/American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) clinical characteristics that the clinician can obtain and document to support a diagnosis of malnutrition<sup>ab</sup>

Clinical characteristic	Malnutrition in the Context of Acute Illness or Injury				Malnutrition in the Context of Chronic Illness				Malnutrition in the Context of Social or Environmental Circumstances			
	Non-severe (moderate) malnutrition		Severe malnutrition		Non-severe (moderate) malnutrition		Severe malnutrition		Non-severe (moderate) malnutrition		Severe malnutrition	
(1) Energy intake (reference 30)	< 75% of estimated energy requirement for > 7 days		≤ 50% of estimated energy requirement for ≥ 5 days		< 75% of estimated energy requirement for ≥ 1 month		< 75% of estimated energy requirement for ≥ 1 month		< 75% of estimated energy requirement for ≥ 3 months		≤ 50% of estimated energy requirement for ≥ 1 month	
<p>Malnutrition is the result of inadequate food and nutrient intake or assimilation; thus, recent intake compared to estimated requirements is a primary criterion defining malnutrition. The clinician may obtain or review the food and nutrition history, estimate optimum energy needs, compare them with estimates of energy consumed and report inadequate intake as a percentage of estimated energy requirements over time.</p>												
(2) Interpretation of weight loss (references 33-36)	%	Time	%	Time	%	Time	%	Time	%	Time	%	Time
The clinician may evaluate weight in light of other clinical findings including the presence of under- or over- hydration. The clinician may assess weight change over time reported as a percentage of weight lost from baseline.	1-2	1 wk	>2	1 wk	5	1 mo	>5	1 mo	5	1 mo	>5	1 mo
	5	1 mo	>5	1 mo	7.5	3 mo	>7.5	3 mo	7.5	3 mo	>7.5	3 mo
	7.5	3 mos	>7.5	3 mos	10	6 mo	>10	6 mo	10	6 mo	>10	6 mo
					20	1y	>20	1y	20	1y	>20	1y
Physical findings (references 36,37)												
Malnutrition typically results in changes to the physical exam. The clinician may perform a physical exam and document any one of the physical exam findings below as an indicator of malnutrition.												
(3) Body fat	Mild		Moderate		Mild		Severe		Mild		Severe	
Loss of subcutaneous fat (eg, orbital, triceps, fat overlying the ribs).												

**Table.** Academy of Nutrition and Dietetics (Academy)/American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) clinical characteristics that the clinician can obtain and document to support a diagnosis of malnutrition<sup>ab</sup> (continued)

Clinical characteristic	Malnutrition in the Context of Acute Illness or Injury		Malnutrition in the Context of Chronic Illness		Malnutrition in the Context of Social or Environmental Circumstances	
	Non-severe (moderate) malnutrition	Severe malnutrition	Non-severe (moderate) malnutrition	Severe malnutrition	Non-severe (moderate) malnutrition	Severe malnutrition
(4) Muscle mass	Mild	Moderate	Mild	Severe	Mild	Severe
Muscle loss (eg, wasting of the temples [temporalis muscle]; clavicles [pectoralis and deltoids]; shoulders [deltoids]; interosseous muscles; scapula [latissimus dorsi, trapezius, deltoids]; thigh [quadriceps] and calf [gastrocnemius]).						
(5) Fluid accumulation	Mild	Moderate to severe	Mild	Severe	Mild	Severe
The clinician may evaluate generalized or localized fluid accumulation evident on exam (extremities; vulvar/scrotal edema or ascites). Weight loss is often masked by generalized fluid retention (edema) and weight gain may be observed.						
(6) Reduced grip strength (reference 42)	N/A <sup>c</sup>	Measurably reduced	N/A	Measurably reduced	N/A	Measurably Reduced
Consult normative standards supplied by the manufacturer of the measurement device.						

<sup>a</sup>A minimum of two of the six characteristics above is recommended for diagnosis of either severe or non-severe malnutrition. Height and weight should be measured rather than estimated to determine body mass index. Usual weight should be obtained in order to determine the percentage and to interpret the significance of weight loss. Basic indicators of nutritional status such as body weight, weight change, and appetite may substantially improve with refeeding in the absence of inflammation. Refeeding and/or nutrition support may stabilize but not significantly improve nutrition parameters in the presence of inflammation. The National Center for Health Statistics defines "chronic" as a disease/condition lasting 3 months or longer (reference 12). Serum proteins such as albumin and prealbumin are not included as defining characteristics of malnutrition because recent evidence analysis shows that serum levels of these proteins do not change in response to changes in nutrient intake (references 22,23,52,53).

<sup>b</sup>This table was developed by Annalynn Skipper PhD, FADA. The content was developed by an Academy workgroup composed of Jane White PhD, RD, FADA, LDN, Chair; Maree Ferguson MBA, PhD, RD; Sherri Jones MS, MBA, RD, LDN; Ainsley Malone, MS, RD, LD, CNSD; Louise Meriman, MS, RD, CDN; Terese Scollard MBA, RD, FADA; and Academy staff member Pam Michael, MBA, RD. Content was approved by an A.S.P.E.N. committee consisting of Gordon L. Jensen, MD, PhD, Co-Chair; Ainsley Malone, MS, RD, CNSD, Co-Chair; Rose Ann Dimaria, PhD, RN, CNSN; Christine M. Framson, RD, PhD, CSND; Nilesh Mehta, MD, DCH; Steve Plogsted PharmD, RPh, BCNSP; Annalynn Skipper, PhD, RD, FADA; Jennifer Wooley, MS, RD, CNSD; Jay Miralzo, RPh, BCNSP Board Liaison; and A.S.P.E.N. staff member Peggi Guenter, PhD, CNSN. Subsequently, it was approved by the A.S.P.E.N. Board of Directors. The information in the table is current as of February 1, 2012. Changes are anticipated as new research becomes available. Adapted from: Skipper A. Malnutrition coding. In Skipper A (ed). *Nutrition Care Manual*. Chicago, IL: Academy of Nutrition and Dietetics; 2012 Edition.

<sup>c</sup>N/A—not applicable.

All information can be found: <https://jandonline.org/action/showPdf?pii=S2212-2672%2812%2900328-0>

# Co-Surgeon or Assistant Surgeon?

**Co-surgery** procedures are one for which “the individual skills of two surgeons are necessary to perform specific surgical procedure or distinct parts of a surgical procedure(s) simultaneously on the same patient during the same operative session.” Co-surgeons can be of the same specialty, though this is more likely to be challenged by the payors so is important to have the necessity for the role clearly documented. Coders will follow the Physician Fee Schedule to determine if **modifier -62** is appropriate. *Not all CPT codes allow a co-surgeon.*

**Example 1:** Dr. X and Dr. Y perform a liver transplant together. Each provider will dictate an operative note to show their significant and unique role or the need for their level of expertise and significant contribution (versus an assistant role). Examples for hepatic transplant would be for the hepatic artery anastomosis, ligations, etc.

**Billing:**

Dr. X: 47135-62 (Liver Transplant)

Dr. Y 47135-62 (Liver Transplant)

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**Example 2:** Dr. Vascular and Dr. Spine performed an arthrodesis together on the lumbar spine which was documented by both providers. Dr. Spine continued to move forward with laminectomy and arthrodesis on the thoracic spine and osteotomy of the lumbar.

**Billing:**

Dr. Vascular: 22558-62 (Arthrodesis, Lumbar)

Dr. Spine: 22558-62(Arthrodesis Anterior Interbody, Discectomy, Lumbar), 22207 (Osteotomy Spine, Lumbar), 22610-51 (Arthrodesis Thoracic), 63046-XS (Laminectomy, Thoracic)

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**Example 3:** Dr. Plastic and Dr. Neuro teamed to perform a cranioplasty, with Dr. Plastic performing a repair with muscle flap.

**Billing:**

Dr. Neuro: 62141-62 (Cranioplasty)

Dr. Plastic: 62141-62 (Cranioplasty), 15733 (Flap), 14302 (Tissue Transfer)

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1322.pdf>



An **Assistant Surgeon** is defined as a provider who actively assists the primary surgeon. The operative note must clearly define the assistant’s role. In a teaching facility, if there is not a qualified resident, this notation must be documented along with the assistant completing the Non-Qualified Resident Form. No separate operative note is required by the Assistant Surgeon. For more information on assistant surgeons, click [here](#).

**If a PA, NP, or CNS assists, modifier -AS will be applied, in addition to -82 (No Qualified Resident Available) if in a teaching facility**

**Example 1:** Patient presents for a partial gastrectomy with vagotomy and removal of their gallbladder. The primary surgeon did not have a qualified resident, notation was made in the operative report, and the assistant completed the NQR attestation form.

**Billing:**

Primary-43635 (Gastrectomy), 47600 (Cholecystectomy)

Assistant: 43635-82, 47600-82

eStar job aids for attestations available on [Hubbl](#)

# CODER INFORMATION

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## Thank you for engagement with documentation/coding!

The newsletters will be distributed monthly. Please let us know if you have burning topics/questions!

- Individual one-on-one sessions with Chelsea Provot, the Surgical Section Coding Educator are available!
- For coding/documentation questions, feel free to reach out to Chelsea Provot or Dr. Raeanna Adams:

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