

Surgery

This section contains instructions for billing surgical procedures not included in the following alphabetized surgery sections. The following sections are categorized primarily by headings used in the *Current Procedural Terminology – 4th Edition*. Refer to the Table of Contents at the beginning of this manual for a list of all surgery section titles.

Note: For assistance in completing claims for surgery services, refer to the *Surgery Billing Examples* section in this manual.

Multiple Surgeries: Select Procedures Not Payable for Same Recipient, Same Date of Service

The following medical policies have been established for certain multiple surgeries when billed for a recipient, by the same provider, for the same date of service. Note the following information:

- Tubal ligations performed at the time of a cesarean section or other intra-abdominal surgery are reimbursable only when billed with CPT-4 code 58611. For more information, refer to the *Hysterectomy* and *Sterilization* sections in this manual.
- A salpingectomy or oophorectomy (CPT-4 codes 58700, 58720, 58900 – 58943) billed on the same date of service as a hysterectomy (CPT-4 codes 58150 – 58285) is not separately reimbursable.
- A vaginal delivery (CPT-4 codes 59400, 59409, 59610 or 59612) billed on the same date of service as a cesarean section (CPT-4 codes 59510, 59514, 59618 or 59620) is not reimbursable unless the claim indicates a multiple pregnancy – one child delivered vaginally and one by cesarean section.
- Policy for intra-ocular lens with cataract surgery is located in the *Surgery: Eye and Ocular Adnexa* section of the provider manual.
- Insertion of a non-indwelling or temporary indwelling bladder catheter (CPT-4 codes 51701 and 51702) is not separately reimbursable when billed with CPT-4 codes 10021 – 69979.
- CPT-4 procedure code 36000 (introduction of needle or intracatheter, vein) is not reimbursable when billed by the same provider for the same recipient on the same date of service with any CPT-4 procedure code within the ranges 00100 – 69999 and 96360 – 96549.

Multiple Surgeries: Billing Vascular Injection With Cardiovascular Procedure

Vascular injection procedures (CPT-4 codes 36000 – 36248 and 36500) are separately reimbursable in conjunction with a major cardiovascular surgical procedure (CPT-4 codes 33361 – 35460, 35500 – 35907) on the same date of service for the same recipient by any provider only if one of the procedures were performed:

- At a different time
- In a different anatomical region

Providers may bill diagnostic radiology CPT-4 codes 75600 – 75893 in support of vascular injection and/or cardiovascular surgical procedures.

Unlisted Surgical CPT-4 Codes Require TAR

CPT-4 codes in the 10000 – 69999 range that include “unlisted” in the descriptor require an approved *Treatment Authorization Request* (TAR). For example, CPT-4 code 59899 that has the descriptor “unlisted procedure, maternity care and delivery” would require approval of a TAR in order to be reimbursed.

Prosthetic Implant

HCPCS code L8699 (prosthetic implant, not otherwise specified) may be billed by surgical providers for reimbursement of internal joint implants inserted during orthopedic procedures. This code is also used to bill for insertion of spinal hardware. Code L8699 must be billed with modifier RT (right side) or LT (left side) as appropriate for bilateral procedures, such as with extremity or hip surgery. Providers should exclude modifier RT or LT from claims for non-bilateral procedures, such as insertion of spinal hardware.

Optional additional modifiers include NU (new equipment [purchase]) and RB (replacement of a part of Durable Medical Equipment furnished as part of a repair). Authorization is required.

Note: Failed prosthetic implants may be replaced, not repaired. Therefore, the optional modifier RB may be used with code L8699 only to indicate “replacement” and not “repair.”

For potentially bilateral prosthetic appliance implants, only one side (modifier RT or LT) is reimbursable for the same recipient, same date of service, using code L8699. Code L8699 should be billed only when a more specific code is unavailable.

For additional important information about billing prosthetic implants, providers should refer to “Surgical Implantable Device Reimbursement” elsewhere in this section.

**Billing for Sling Graft
Repair Device**

HCPCS code C1771 (repair device, urinary, incontinence, with sling graft) is reimbursable to providers, with the following restrictions:

- It must be billed with either ICD-9-CM diagnosis code 625.6 (stress incontinence, female) or 788.32 (stress incontinence, male).
- Providers must bill the code “By Report” and attach a copy of the invoice with the claim.
- It may no longer be billed with code L8699 (prosthetic implant, not otherwise specified).

Pulse Oximetry

CPT-4 code 94760 (non-invasive ear or pulse oximetry for oxygen saturation; single determination) is reimbursable only to physicians when no other services are billed for the same recipient, by the same provider on the same date of service.

**Examination of
Tissue Specimens:
Reimbursement Restrictions**

Surgeons will not be separately reimbursed for examining tissue specimens they obtain during surgery (CPT-4 surgical procedure codes 10000 – 69999) when such tissue(s) is subsequently submitted to another provider for individual examination and pathologic diagnosis (CPT-4 codes 88300 – 88309). Surgical pathology services rendered to the same recipient, for the same service, are reimbursable to only one provider. Therefore, claims for codes 88302 – 88309 will be denied if such services were previously paid to any provider for the same procedure and recipient.

Surgeons may be reimbursed for the surgical pathology if they perform the surgical pathology service and do not send the specimen to another provider who performs the examination and pathologic diagnosis. However, examination of tissue specimens in the operating room by the operating surgeon (a service that is not separately identifiable and for which no procedure code exists) is considered part of the surgical procedure.

Reminder: Tissue examination is an integral part of micrographic surgery. Therefore, claims for codes 88302 – 88309 will be denied if codes 17311 – 17315 (Mohs' micrographic surgery) were previously reimbursed to any provider for the same recipient and date of service. Conversely, reimbursement for codes 17311 – 17315 will be reduced if codes 88302 – 88309 have been previously reimbursed to any provider for the same procedure, recipient and date of service.

CPT-4 codes 88302 – 88309 may be separately reimbursed if documentation is provided that the pathology claims are for different specimens.

Code 88314 (histochemical staining) is not reimbursable with codes 17311 – 17315 for a routine frozen section stain. Code 88314 is reimbursable when billed with CPT-4 codes 17311 – 17315 for a non-routine frozen section stain when billed with modifier 59.

Scoliosis Surgery and Somatosensory Tests

Coverage of evoked response testing includes somatosensory evoked response (CPT-4 codes 95925 – 95927 and 95938) when used for continuous monitoring during scoliosis corrective surgery. Claims for codes 95925 – 95927 and 95938 as a monitoring procedure must indicate the duration of the monitoring.

For information about reimbursement for somatosensory testing, please see "Evoked Response Testing" in the *Medicine: Neurology and Neuromuscular* section of the appropriate Part 2 provider manual.

Same Day Surgical Admissions: Guidelines and Exceptions

When possible, same day admission for elective surgical procedures is expected. This can be accomplished by pre-admission lab and X-ray testing and by educating patients and the family regarding pre-surgical and surgical requirements including fasting and medications. Exceptions require authorization and documentation on the *Treatment Authorization Request* (TAR). Many planned surgical procedures can be done with one day's hospitalization and, where appropriate, authorizations will be limited to this length of stay.

Surgical Centers

Providers are reimbursed for medical procedures performed in a surgical center (Place of Service code "24") if the descriptor of the procedure code indicates that it includes general anesthesia.

In some cases, medical procedures require the administration of general anesthesia, making them appropriate for reimbursement when the service is provided in a surgical center.

Providers should indicate the procedure code descriptor in the *Reserved for Local Use* field (Box 19) of the *CMS-1500* claim form when a medical procedure requiring general anesthesia is billed with Place of Service code "24."

Voice Bak Prosthesis

The Voice Bak Prosthesis device is a benefit for laryngectomees who have undergone the necessary cervical esophagostomy.

Billing Procedures

This prosthesis should be billed with procedure code 99070. The manufacturer's invoice must be attached to the claim. A TAR is not required. This prosthesis may be billed only by a physician or a designate on behalf of the physician. Replacement parts are identified by the manufacturer's catalog number and reimbursed at catalog prices.

Surgical Implantable Device Reimbursement

Reimbursement for surgical implantable devices is based on the following policy:

- Since implantable devices are considered surgical supplies, they are only reimbursable if the associated surgical procedure is performed for the same recipient and same date of service. The claim for the implantable device may be separate from the claim for the operative procedure

- Implantable devices are reimbursed at full invoice cost with no markup, up to six months following the implant date. Reimbursement is automatically reduced by the system for claims submitted between seven and 12 months after the implant date. Providers may bill for an implantable device up to one year after the actual date of the surgical procedure. No payment is allowed past one year from the implant date.

Providers are reminded that failure to submit a manufacturer or distributor invoice with a claim for a surgical implantable device will result in denial of the claim. Claims submitted with a catalog page or a purchase order will be denied.

- Providers may use the “over one year billing exceptions” explained in the *CMS-1500 Submission and Timeliness Instructions* or *UB-04 Submission and Timeliness Instructions* section of the provider manual on the claim, if appropriate.
- Providers are reminded that the following information applies to either an invoice or attachment.
 - These invoices must have the manufacturer’s or distributor’s name and address on the invoice and must be produced by the manufacturer or distributor. The hospital must also provide the following whether it is on an invoice or attachment.
 - ❖ Patient’s full name and Medi-Cal recipient number
 - ❖ Name of the physician
 - ❖ Facility name where the implant procedure occurred
 - ❖ Date of the surgical implant procedure and the company contact information

Note: All of the above items must be included in order for the claim to be paid.

Gender Identity Disorder

Treatment for Gender Identity Disorder (GID) is a covered Medi-Cal benefit when medical necessity has been demonstrated. Treatment should follow the latest version of the World Professional Association for Transgender Health (WPATH) document, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*.

Covered Benefits

Covered Medi-Cal benefits include:

- Psychotherapy
- Continuous hormonal therapy
- Laboratory testing to monitor hormone therapy, and
- Gender reassignment surgery that is not cosmetic in nature

Gender reassignment surgery is covered when the individual with GID is at least 18 years of age, has the capacity for fully-informed consent, and the WPATH criteria for the surgery have been met. Covered benefits include: mastectomy, orchiectomy, hysterectomy, salpingo-oophorectomy, ovariectomy and genital surgery, including placement of testicular prostheses when indicated.

Augmentation mammoplasty for male-to-female individuals (MtF) is a covered benefit only when an appropriate trial of hormone therapy has not resulted in breast enlargement.

Intersex surgery should not be requested or billed using CPT-4 code 55970 (intersex surgery; male to female) or CPT-4 code 55980 (intersex surgery; female to male). Due to the serial nature of surgery for the gender transition, CPT-4 coding should be specific for the procedures performed during each operation. A *Treatment Authorization Request (TAR)* is necessary only for procedures that currently require a TAR.

Non-Covered Benefits

The following surgeries are considered cosmetic in nature and are not covered Medi-Cal benefits:

- Reduction thyroid chondroplasty
- Rhinoplasty
- Facial bone reconstruction
- Face lift, blepharoplasty
- Voice modification surgery
- Hair removal or transplant, and
- Liposuction

Augmentation mammoplasty is not a covered benefit for MtF individuals except as noted above.

Pleural Cavity Procedures

CPT-4 code 32550 (insertion of indwelling tunneled pleural catheter with cuff) is not reimbursable with CPT-4 codes 32554 – 32557 when performed on the same side of the chest.

The following CPT-4 codes are not reimbursable with CPT-4 codes 32550 and 32551 when performed on the same side of the chest.

CPT-4

<u>Code</u>	<u>Description</u>
32554	Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance
32555	with imaging guidance
32556	Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance
32557	with imaging guidance

Providers must document when the procedure is performed on the opposite side of the chest in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim or on an attachment.

Modifier 50

Do not bill with modifier 50 (bilateral procedures) for the following CPT-4 codes:

CPT-4

<u>Code</u>	<u>Description</u>
64642	Chemodenerivation of one extremity; 1 – 4 muscle(s)
64643	each additional extremity, 1 – 4 muscle(s)
64644	Chemodenerivation of one extremity; 5 of more muscles
64645	each additional extremity, 5 or more muscles
64646	Chemodenerivation of trunk muscle(s); 1 – 5 muscle(s)
64647	6 of more muscles