

SECTION 11 SURGERY

PROCEDURE CODES

MO HealthNet recognizes the CPT and HCPCS surgery procedure codes and follows the code descriptions listed in the current editions of the publications when reviewing claims. Specific knowledge of the procedures and services performed by the physician is vital in assigning the proper CPT and HCPCS codes. Systems should be in place to correctly transmit information between the physician and the coder.

POST-OPERATIVE CARE

Post-operative care includes 30 days of routine follow-up care for those surgical procedures having a MO HealthNet reimbursement amount of \$75.00 or more. For counting purposes, the date of surgery is the first day.

This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center, rural health clinic (RHC) or an office setting; and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, RHC, office, home, nursing home, etc.).

Supplies necessary for providing follow-up care in the office, such as splints, casts and surgical dressings in connection with covered surgical procedures, may be billed under the appropriate office supply code. See Section 13 for the list of office supply codes.

INCIDENTAL/SEPARATE SURGICAL PROCEDURES

Surgeries considered incidental to, or a part of another procedure, performed on the same day, are **not** paid separately, but rather are included in the fee for the major procedure. Determine if the surgery is considered incidental by asking yourself if it is a necessary part of the surgery or was the surgery “incidentally” performed, e.g. a laparoscopy that precedes a laparotomy. For information on procedures that are not paid when incidental to other specified services, see Section 13.42 of the MO HealthNet *Physician Provider Manual*.

Separate procedures are defined as a service performed independently of, and is not immediately related to other services. When performed alone for specific and documented purposes, it may be reported. The procedure should not be billed unless it is performed by itself or is not immediately related to other services being performed during the same session.

MULTIPLE SURGICAL PROCEDURES

Multiple surgical procedures performed on the same participant on the same date of service by the same provider for the same or separate body systems through separate incisions are to be billed out separately for each procedure. The important factor in

coding multiple surgical procedures is to list the surgeries in order of importance or significance for payment, not necessarily always listing the most time consuming procedure first. Claims for multiple surgeries are reimbursed according to the following:

- 100% of the allowable fee for the major procedure
- 50% of the allowable fee for the secondary procedure
- 25% of the allowable fee for the third procedure

An operative report must always accompany claims with multiple surgical procedures on the same participant on the same date of service.

ASSISTANT SURGEON

MO HealthNet adheres to the guidelines set by Medicare Services for assistants at surgery. The services of an assistant surgeon are billed with modifier 80. Reference the Medicare Physician Fee Schedule Relative Value File (Medicare Physician Fee Schedule Database). The MPFSRVU (MPFSDB) indicators in the assistant surgeon column of the database instruct carriers how to reimburse for services. The fee schedule can be found at <http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp>.

NOTE: Not all codes in the listing are covered by MO HealthNet, refer to the MO HealthNet fee schedule at http://dssapp2.dss.mo.gov/pricelistx/main_disclaimer.shtml.

An assistant surgeon's fee is payable at 20% of the surgeon's fee for the surgical procedure. Only one assistant surgeon can be paid for those procedures that warrant an assistant. If the surgeon's claim is systematically priced, the assistant surgeon's claim is also systematically priced. If the surgeon's claim is manually priced, the assistant surgeon's claim is also manually priced, and an operative record *must* be attached to the claim for payment.

Follow-up care provided by the assistant surgeon is subject to the 30-day postoperative policy as described in the MO HealthNet *Physician Provider Manual*, Section 13.41.

Registered nurses and other non-physician personnel are ancillary staff and *not* considered "assistant surgeons" and services performed by them are, therefore, *not* billable to MO HealthNet as a separate service.

The surgeon and assistant surgeon *must* each submit separate professional claims for services provided, using his/her individual NPI.

MO HealthNet does *not* reimburse for the services of an assistant surgeon when a co-surgeon is used.

A clinic may submit a single professional claim for the surgeon and assistant surgeon, using the clinic's NPI and *must* also include each individual provider's NPPI as the performing/rendering provider.

NOTE: For assisting at cesarean deliveries, the appropriate procedure code for the delivery only *must* be billed, regardless of whether or not the surgeon billed the global procedure. A “global” delivery indicates that the prenatal care, delivery and postpartum care are provided by a single physician; therefore global delivery procedure codes may *not* be billed by the assistant surgeon.

CO-SURGEONS

“Co-Surgeons” are defined as two primary surgeons working simultaneously performing distinct parts of a total surgical service, during the same operative session. Each physician should submit separate claims, using his/her own individual/clinic NPI number. The surgical procedure code together with modifier “62” should be shown on both claims. The name of both surgeons must appear on the claim form in the “description” area (field 24d on the CMS-1500), with a description of the entire (total) procedure performed. An operative report must be attached to each claim and the operative report should justify the necessity of two surgeons. These claims cannot be billed electronically and are manually priced by the medical consultant.

CONSULTATIONS

A consultation is when a physician renders an opinion or advice at the request of another physician. It is **not** a referral of a patient to another physician for care and treatment. A consultation must always include a written report sent back to the requesting physician. The written report must include all findings, the opinion of the consulting physician, and advice or recommendations for patient treatment. When a consulting physician begins to “treat” rather than advise on treating, then it ceases to be a consultation. At that time, the consulting physician becomes an attending physician for the patient and should use appropriate levels of service codes based on the place of service.

CONSULTATION CODES

Office/Outpatient Consult Codes

99241
 99242
 99243
 99244
 99245 (requires a copy of the consult report with the claim)

In-patient Consult Codes

99251
 99252
 99253
 99254
 99255 (requires a copy of the consult report with the claim)