



519.16 SURGICAL SERVICES

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DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

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POLICY METADATA

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BACKGROUND

West Virginia Medicaid covers medically necessary surgical procedures and requires prior authorization for all inpatient and specific outpatient procedures.

POLICY

519.16.1 COVERED SERVICES

Under Medicaid Resource Based Relative Value Scale (RBRVS) payment rules, physicians are paid a single global fee for all necessary services. Payments are not made for individual components of a complete or bundled procedure. Refer to the BMS [RBRVS RVU](#) file for multiple surgeries, bilateral surgery, co-surgery, team surgery and assistant-at-surgery procedures indicated with a "Y" (Refer to Appendix A in the current [CMS RBRVS RVU file](#) for a legend of status codes).

Procedures/service codes that are bundled into a primary procedure/service will not be reimbursed. Unbundled codes are not eligible for reimbursement. Multiple surgery payment rules apply to most surgical services except when the CPT code(s), by definition, are multiple procedures. When multiple surgeries are performed during the same operative session, payment is based on the full amount for the primary procedure and 50% of the fee for any other necessary and appropriate procedures performed during the session. The appropriate modifier must be included on the claim.

Only one assistant-at-surgery per surgical encounter is reimbursable. An assistant-at-surgery is not reimbursable when co-surgeon(s) or team surgery is billed. The appropriate modifier must be included on the claim with the appropriate service code for payment consideration.

If the surgical procedure does not require prior authorization, the assistant-at-surgery must include the same CPT code as the surgeon with the appropriate modifier on the CMS-1500 claim form and attach the operative report documenting their role during the procedure. The claim must be submitted with the operative report to BMS Fiscal Agent for payment consideration. When documentation is not available, the assistant-at-surgery services are not separately reimbursable.

A preoperative visit and follow-up care are bundled with the payment for the surgery and are not separately reimbursed. However, follow-up care may be reimbursed to other practitioners, such as an optometrist providing follow-up care for an ophthalmologist.

Surgical procedures performed in an Emergency Department (ED) are reimbursable. However, the

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physician is not reimbursed for an ED visit in addition to a surgical procedure performed in the ED on the same date of service. Refer to [Chapter 510, Hospital Services](#) for additional information.

519.16.2 PRIOR AUTHORIZATION

West Virginia Medicaid requires Prior Authorization for ALL hospital admissions and specific surgeries performed in offices, outpatient hospital settings, and ambulatory surgical centers. In addition, specific practitioner services and all unlisted codes for procedures/services require Prior Authorization.

For outpatient surgical procedures that require prior authorization, the surgeon must request prior authorization via the Utilization Management Contractor's (UMC) web-based portal, <https://c3wv.apshealthcare.com>. Nationally accredited, evidence-based, medically appropriate criteria, such as InterQual, or other medical appropriateness criteria approved by BMS, are utilized for reviewing medical necessity of services requested.

If the surgery is authorized by the UMC, separate prior authorization numbers for the surgeon and the outpatient facility are assigned. The surgeon or facility may access the prior authorization number via the web-based portal. The prior authorization number must be included on the claim form in order to be eligible for reimbursement.

When the procedure requires prior authorization, the UMC must be informed if an assistant-at-surgery is planned to participate in the procedure by the treating surgeon. If the procedure and the assistant-at-surgery are approved by the UMC, when billing, the assistant-at-surgery must include the same CPT code as the surgeon with the appropriate modifier and prior authorization number. The claim form must be submitted to the BMS Fiscal Agent for payment consideration.

Note: Mastectomy or related covered reconstructive procedures will not require prior authorization for individuals diagnosed with breast cancer.

Retrospective authorization is available by the UMC in the following circumstances:

- A procedure/service denied by the member's primary payer, providing all requirements for the primary payer have been followed, including appeal processes; or
- Retroactive West Virginia Medicaid eligibility.

Refer to [Chapter 100, General Administration and Information](#) for additional information.

519.16.3 NON-COVERED SERVICES

No surgical procedure will be covered on an inpatient basis if the procedure can be performed appropriately and safely in a physician's office or other outpatient setting.

The BMS [RBRVS RVU](#) file lists non-covered surgical services. Non-covered services also include, but are not limited to:

- **Cosmetic Surgery:** West Virginia Medicaid does not cover elective cosmetic surgery or services required as a result of complications from cosmetic surgery. Cosmetic surgery is defined as

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surgery having the primary purpose of improving the member's appearance and is not medically necessary. Examples of non-covered elective cosmetic surgeries include, but are not limited to otoplasty, rhinoplasty (except to correct internal nasal deformity), nasal reconstruction, osteoplasty for prognathism or micrognathia, dermabrasion, specific skin grafts, fascioplasty, lipectomy, liposuction, replacement of breast implants used for purposes other than reconstruction due to cancer, and application/removal of tattoos.

- Procedures considered investigational or experimental

Non-covered services are not eligible for a DHHR Fair Hearing or a Desk/Document review.

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter.

Assistant-at-Surgery – A qualified, employed registered nurse or an advanced registered nurse practitioner or physician assistant licensed by the state in which they practice AND under the direct supervision of the surgeon, who provides aid in exposure, hemostasis, and other technical functions that assist the surgeon to perform a safe operation with optimal results for the member. The role of the Assistant-at-Surgery during the operative procedure must be documented in the operative report for consideration of reimbursement.

Assistant Surgeon – A physician who actively assists an operating surgeon in the performance of a surgical procedure. One physician acts as the surgeon and the other acts as an assistant. This is usually necessary because of the complex nature of the procedure(s) or the patient's condition. The assistant surgeon performs medical functions under the direct supervision of the operating physician. The assistant is generally in the same specialty as the operating surgeon.

Co-Surgeon – When 2 surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon must report their distinct operative work by reporting the same surgical procedure code.

Minimum Assistant Surgeon - The surgeon services are only required for a short period during the procedure.

REFERENCES

[Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program \(MBSAQIP\)](#)

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter			TBD