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## Surgery

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This section contains instructions for billing surgical procedures not included in the following alphabetized surgery sections.

**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® code 58611.» For more information, refer to the *Hysterectomy* and *Sterilization* sections in this manual.
- A salpingectomy or oophorectomy (CPT codes 58700, 58720, 58900 thru 58943) billed on the same date of service as a hysterectomy (CPT codes 58150 thru 58285) is not separately reimbursable.
- A vaginal delivery (CPT codes 59400, 59409, 59610 or 59612) billed on the same date of service as a cesarean section (CPT 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 codes 51701 and 51702) is not separately reimbursable when billed with CPT codes 10021 thru 69979.
- CPT 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 procedure code within the ranges 00100 thru 69999 and 96360 thru 96549.

## **Multiple Surgeries: Billing Vascular Injection With Cardiovascular Procedure**

Vascular injection procedures (CPT codes 36000 thru 36248 and 36500) are separately reimbursable in conjunction with a major cardiovascular surgical procedure (CPT codes 33361 thru 35400, 35500 thru 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 codes 75600 thru 75893 in support of vascular injection and/or cardiovascular surgical procedures.

## **Unlisted Surgical CPT Codes Require TAR**

CPT codes in the 10000 thru 69999 range that include “unlisted” in the descriptor require an approved *Treatment Authorization Require* (TAR). For example, CPT 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 ICD-10-CM diagnosis code N39.3 (stress incontinence [female] [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 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 surgical procedure codes 10000 thru 69999) when such tissue(s) is subsequently submitted to another provider for individual examination and pathologic diagnosis (CPT codes 88300 thru 88309). Surgical pathology services rendered to the same recipient, for the same service, are reimbursable to only one provider. Therefore, claims for codes 88302 thru 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 thru 88309 will be denied if codes 17311 thru 17315 (Mohs' micrographic surgery) were previously reimbursed to any provider for the same recipient and date of service. Conversely, reimbursement for codes 17311 thru 17315 will be reduced if codes 88302 thru 88309 have been previously reimbursed to any provider for the same procedure, recipient and date of service.

CPT codes 88302 thru 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 thru 17315 for a routine frozen section stain. Code 88314 is reimbursable when billed with CPT codes 17311 thru 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 codes 95925 thru 95927 and 95938) when used for continuous monitoring during scoliosis corrective surgery. Claims for codes 95925 thru 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 *Additional Claim* Information field (Box 19) of the *CMS-1500* claim form when a medical procedure requiring general anesthesia is billed with Place of Service code “24.”

## **Laryngoplasty**

The following laryngoplasty CPT codes for laryngeal stenosis, with graft, are reimbursable for recipients of the following ages:

CPT Code	Age Restriction
31551	11 years of age or younger
31552	12 years of age or older
31553	11 years of age or younger
31554	12 years of age or older

## **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.

## **Larynx Devices and Prostheses (L8500 thru L8510)**

### **Coverage**

Larynx devices and prostheses may be authorized and reimbursed for recipients that meet the established criteria.

### **Criteria**

The recipient has had an amputation or removal of a body part and requires one or more of the following:

- A device to enable speaking in the absence of the larynx (L8500, L8501); or
- A replacement battery or accessory for an artificial larynx (L8505); or
- A trachea-esophageal voice prosthesis (L8507, L8509); or
- A voice amplifier (L8510)

### **Authorization and Restrictions**

HCPCS codes L8500 and L8505 always require authorization (TAR required).

**«Hernia Repair**

The following procedure codes for hernia repair are Medi-Cal benefits:

<b>CPT Code</b>	<b>Description</b>
49591	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
49592	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated
49593	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible
49594	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated
49595	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible
49596	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated
49613	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible

**Note:** CPT codes in the 49591, 49593, 49595 and 49613 require an approved *Treatment Authorization Request (TAR)*.»

## «Hernia Repair (continued)»

CPT Code	Description
49614	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated
49615	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible
49616	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated
49617	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible
49618	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated
49621	Repair of parastomal hernia, any approach (i.e., open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible
49622	Repair of parastomal hernia, any approach (i.e., open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated
49623	Removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (i.e., open, laparoscopic, robotic) (List separately in addition to code for primary procedure)

**Note:** CPT codes in the 49615, 49617 and 49621 require an approved *Treatment Authorization Request (TAR)*.»



## **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 name and address of the manufacturer or distributor 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 the above items must be included in order for the claim to be paid.

## **«Surgical Insertion, Removal, or Replacement of Breast Implants**

Claims for surgical insertion, removal, or replacement of breast implants (CPT codes 19328, 19330, 19340, 19342, 19396, and 19499) require authorization but should not be billed “By Report.”

The following CPT codes require a *Treatment Authorization Request* (TAR) from a primary surgeon and/or provider.

<b>CPT Code</b>	<b>Description</b>
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (e.g., saline, silicone gel, etc.)
19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19396	Preparation, moulage for custom breast implant
19499	Unlisted procedure, breast

The insertion, removal, or replacement of breast implants is reimbursable as reconstructive surgery when medically necessary, which includes but is not limited to trauma, infection, tumors, or disease.

Examples:

- Removal breast implants due to a diagnosis of breast cancer, or
- Rupture of a breast implant, or
- Removal of an intact implant if the contralateral implant is removed due to rupture or other medical condition necessitating its removal, to preserve breast symmetry/normal appearance.>>

**Note:** ‹‹The insertion, removal, or replacement of breast implants for exclusively cosmetic reasons are not covered.

Documentation of medical necessity should be maintained in the recipient’s medical record.››

## **Gender Override**

Instructions for overriding gender differences for procedures are in the *Transgender and Gender Diverse Services* section in the appropriate Part 2 provider manual.

## **Pleural Cavity Procedures**

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

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

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

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

## **Legend**

Symbols used in the document above are explained in the following table.

<b>Symbol</b>	<b>Description</b>
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
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