519.16 SURGICAL SERVICES

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BACKGROUND

West Virginia Medicaid covers surgical procedures with 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 surgical services. Payments are not made for individual components of a complete or bundled procedure. Refer to the Bureau for Medical Services (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 Current Procedural Terminology (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 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) portal. Nationally accredited, evidence-based, medically appropriate criteria, such as InterQual, or other medical appropriateness criteria approved by BMS, are utilized for reviewing 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.

Procedures not covered include, but are not limited to:

- Abdominoplasty
- Adam's Apple reshaping
- Blepharoplasty
- Body contouring
- Brachioplasty
- Brow augmentation, reduction, lift, recontouring
- Buccal fat removal/chin reduction
- Buttock enhancement
- Calf implants
- Cheek/Malar implants/augmentation
- Chemical peel
- Chin/nose implants or prosthesis (Genioplasty or Mentoplasty)/augmentation
- Chin, cheek, or jaw reshaping

- Chondrolaryngoplasty
- Collagen injections
- Dermal fillers
- Dermabrasion
- Ear pinning
- Earlobe reduction
- Electrolysis, hair removal
- Facelift
- Facial implants
- Facial feminization
- Forehead lengthening
- Frontal cranioplasty
- Gluteal augmentation
- Gluteal Implants
- Hairline advancement
- Hair transplantation/implants or reconstruction
- Hip Implants
- Jaw augmentation, reduction, recontouring
- Laryngoplasty
- Laser of skin or veins
- Laser hair removal
- Laser skin resurfacing
- Lip augmentation
- Lip reduction
- Lipofilling
- Liposuction
- Mastopexy
- Neck lift, tightening, platysmaplasty
- Nose reshaping
- Orbital rim recontouring
- Otoplasty
- Pectoral implants for chest masculinization
- Penile transplantation
- Reduction rhinoplasty
- Reduction thyroid chondroplasty
- Removal of redundant skin
- Rhinoplasty
- Rhytidectomy or laser rhytidectomy
- Scalp advancement or reduction
- Tattoos
- Uterine transplantation
- Voice modifications such as laryngoplasty, glottoplasty, or shortening of the vocal cords
- Lip augmentation
- Thyroid cartilage enhancement

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 two 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

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Surgical Services	January 15, 2016
Entire Chapter	Updated Background and Non-Covered Services in 519.16.3	August 1, 2023