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POLICY TRANSMITTAL NO. 06-56	DATE: DECEMBER 18, 2006
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS & POLICY

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TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-2; 30-5-8; 30-5-22; 30-5-24; 35-3-2; and 45-7-1.

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

Rules are revised to add clarification to pre and post operative billing procedures. Current rules exclude payment for pre and post operative care outside of the global payment. However, current CPT guidelines provide for a separate payment for evaluation services provided prior to the decision to perform surgery has been made.

Rules are revised to allow coverage for first trimester ultrasounds and additional ultrasounds as needed for high risk pregnancies. Through the use of high risk ultrasounds, the provider can more accurately determine the estimated due date which enhances the probability of positive birth outcomes.

Non-emergency transportation (NET) rules are revised to exclude the capitated payment and transportation services for individuals who reside in an institution for Mental Disease.

O-EPIC rules are revised to increase the maximum number of employees that an employer may have on its payroll in order for the employer to participate in the O-EPIC Premium Assistance program from 25 employees or less to 50 employees or less.

Original signed on 12-18-06

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Mary Stalnaker, Director  
Family Support Services Division

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Sharon Neuwald, Coordinator  
Office of Legislative Relations and Policy

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WF # 06-Y (DT)

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## **INSTRUCTIONS FOR FILING MANUAL MATERIAL**

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following a “DHS” number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The “340” is the Title number that designates DHS as the rulemaking agency; the “2” specifies the Chapter number; and the “1” specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-6392.

### **REMOVE**

317:30-5-2

317:30-5-8

317:30-5-22

317:30-5-24

317:35-3-2

317:45-7-1

### **INSERT**

317:30-5-2, pages 1-12, revised 10-8-06

317:30-5-8, pages 1-11, revised 10-8-06

317:30-5-22, pages 1-3, revised 10-18-06

317:30-5-24, pages 1-2, revised 10-18-06

317:35-3-2, pages 1-3, revised 8-2-06

317:45-7-1, 1 page only, revised 10-8-06

**317:30-5-2. General coverage by category**

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Authority's medical programs, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services may be based on a determination made by the medical consultant in individual circumstances.

(1) Coverages include the following:

(A) Medically appropriate inpatient hospital visits are covered for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgicenter or a Medicare certified hospital that offers outpatient surgical services. Refer to the List of Covered Surgical Procedures.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for member with proven malignancies or opportunistic infections.

(G) Direct physicians' services are covered on an outpatient basis. A maximum payment of four visits are covered per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.

(H) Direct physicians' services in a nursing facility for those members approved for nursing care. Payment is made for a maximum of two nursing facility visits per month. To receive payment for a second nursing facility visit in a

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month denied by Medicare for a Medicare/SoonerCare patient, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Payment is made for medically necessary diagnostic x-ray and laboratory work.

(J) One screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow-up mammograms. This includes interpretation and technical component.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure. Payment is made based upon an invoice for the item.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs under the jurisdiction of the Authority. A copy of the authorization, DHS form ABCDM-16, Authorization for Examination and Billing, must accompany the claim.

(N) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

(O) Family planning - including sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and, with their physician, execute the Federally mandated consent form (ADM-71). A copy of the consent form must be attached to the claim form. Separate payment is made for an I.U.D. inserted during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception are not covered. Reversal of sterilization procedures may be covered when medically indicated and substantiating documentation is attached to the claim. The Norplant System for birth control is covered; however, removal of the Norplant System prior to five years is covered only when

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documented as medically necessary. Reinsertion of Norplant contraceptive will be considered on a case by case basis.

(P) Genetic counseling (requires special medical review prior to approval).

(Q) Blood count weekly for members receiving the drug Clozaril.

(R) Complete blood count and platelet count prior to receiving chemotherapeutic agents or radiation therapy and for members receiving medication such as DPA-D-Penicillamine on a regular basis for treatment other than malignancies.

(S) Payment of ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(T) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with Federal regulations.

(U) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;

(iii) Hold unrestricted license to practice medicine in Oklahoma;

(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;

(v) Seeing members without supervision;

(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;

(vii) Submit billing in own name with appropriate Oklahoma

SoonerCare provider number.

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

(V) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and sign off on the billed encounter;

(ii) Attending physician present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(W) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The member must be at least minimally examined and reviewed by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) This contact must be documented in the medical record.

(X) Payment to a physician for supervision of CRNA services unless the CRNA bills directly.

(Y) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

(Z) Organ and tissue transplantation services for children and adults, limited to bone marrow, stem cells, cornea, heart, kidney, liver, lung, SPK (simultaneous pancreas

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kidney), PAK (pancreas after kidney), and heart-lung, are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

(i) All transplantation services, except kidney and cornea, must be prior authorized to be compensable.

(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(iii) To be compensable under the SoonerCare program all organ transplants must be performed at a Medicare approved transplantation center.

(iv) Finally, procedures considered experimental or investigational are not covered.

(AA) Total parenteral nutritional therapy for certain diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(EE) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the patient to describe their smoking use;

(II) Advising the patient to quit;

(III) Assessing the willingness of the patient to quit;

(IV) Assisting the patient with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP capitation payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note and signature along with the patient specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(2) General exclusions include the following:

(A) Inpatient diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the codes for subsequent hospital care should

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be used.

(D) Refractions and visual aids.

(E) A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of persons who are under 21 years of age, mentally incompetent or institutionalized. Reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomy.

(I) Medical services considered to be experimental or investigational.

(J) Payment for more than four outpatient visits per month (home or office) per member except those visits in connection with family planning, or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

(M) Physician supervision of hemodialysis or peritoneal dialysis.

(N) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(P) Payment for the services of physicians' assistants, social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out.

(Q) Induced abortions, except when certified in writing by a

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physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (See OAC 317:30-5-6 or 317:30-5-50.)

(R) Night calls or unusual hours.

(S) Speech and Hearing services.

(T) Mileage.

(U) Other than routine hospital visit on date of discharge unless member expired.

(V) Direct payment to perfusionist as this is considered part of the hospital cost.

(W) Inpatient chemical dependency treatment.

(X) Fertility treatment.

(Y) Routine immunizations.

(Z) Payment for removal of benign skin lesions unless medically necessary.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's medical programs, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for patients under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services will be prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(A) Effective October 1, 1993, all residential and acute psychiatric services will be authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25.

(B) Out of state placements will not be authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the state, treatment for medical services will be covered in the same way as they would be covered within the state. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options.

(A) Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation which validates the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.25. Requests shall be made prior to the expiration of the approved inpatient stay.

(B) All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** SoonerCare utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment**

**program.** Payment is also made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Title 21, Oklahoma Statutes, Section 846, as amended, states in part: *Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of eighteen (18) years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of eighteen (18) years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above. Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought as a result of the report.*

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient

consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the codes for subsequent hospital care should be used.

(D) A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of persons who are under 21 years of age.

(G) Non-therapeutic hysterectomy.

(H) Medical Services considered to be experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (See OAC 317:30-5-6 or 317:30-5-50.)

(K) Physician supervision of hemodialysis or peritoneal dialysis.

(L) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(M) Payment for the services of physicians' assistants except as specifically set out.

(N) Direct payment to perfusionist as this is considered part of the hospital cost.

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(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(P) Night calls or unusual hours.

(Q) Mileage.

(R) Other than routine hospital visit on date of discharge unless patient expired.

(S) Tympanometry.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. For in-State physicians, claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits will reflect a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with SoonerCare within 90 days of the date of Medicare payment in order to be considered timely filed. The Medicare EOMB must be attached to the claim. If payment was denied by Medicare Part B, and the service is a SoonerCare covered service, mark the claim "denied by Medicare".

(1) Out of state claims will not "cross over". Providers must file a claim for coinsurance and/or deductible within 90 days of the Medicare payment. The Medicare EOMB must be attached to the claim.

(2) Claims filed under SoonerCare must be filed within one year from the date of service. For dually eligible members, to be eligible for payment of coinsurance and/or deductible under SoonerCare, a claim must be filed with Medicare within one year from the date of service.

**317:30-5-8. Surgery**

(a) **Use of surgical modifiers.** The Physicians' Current Procedural Terminology (CPT) provides for 2-digit surgical modifiers to further describe surgical services. All of these modifiers must be used on OHCA claims when applicable. The CPT also provides an alternate method of using a special 5-digit code beginning with 099--. These codes will not be accepted by OHCA. This method cannot be used to record modifications to the procedure code. Use the appropriate 2-digit modifier placed just to the right of the 5-digit surgical procedure code.

(b) **Description of modifiers and how they are paid.**

(1) -20 Microsurgery - OHCA does not make an additional payment for this modifier. The procedure will be paid at the regular OHCA allowable.

(2) -22 Unusual services - OHCA does not make an additional payment for this modifier. The procedure will be paid at the regular OHCA allowable.

(3) -26 Professional component - This modifier is used to identify a professional component. It is used when the physician provides an interpretation rather than a full-service procedure. Modifier -26 will also be used by the hospital-based radiologist or pathologist on radiology, surgical pathology and echocardiography done in the hospital. The allowables for modifier -26 are listed in the Authority's listing of the procedure-based maximum allowable payments.

(4) -47 Anesthesia by surgeon - OHCA does not make an additional payment for this modifier. OHCA does not make an additional payment for local anesthesia. OHCA will pay additional for surgical procedure codes 62274 through 62279 and nerve block, codes 64400 through 64530. These codes are used by surgeons or obstetricians when applicable without modifier -47. The procedure will be paid at the regular OHCA allowable. Anesthesia coding and methodology is described at the front of the CPT for the practicing anesthesiologist.

(5) -50 Bilateral procedure and - 51 Multiple surgery - There has been some misunderstanding about the use of modifier -50 (bilateral surgery) and -51 (multiple surgery). These modifiers are not interchangeable. They have very different meanings and

result in very different payments.

(A) Bilateral Procedure. This modifier is to be used when there is no specific code in the CPT for a bilateral procedure. List the bilateral procedure on one line followed by modifier -50. The payment will be 150 percent of the base allowable for the procedure so it is no longer necessary to list the procedure twice on a claim when it is bilateral. The units of service are shown as "1".

(B) Multiple surgery. When a surgeon or assistant surgeon performs multiple surgery, modifier -51 is applied to the secondary procedures. The multiple surgery rule provides that the second and subsequent surgeries are paid at a lesser amount. The major procedure is listed without a -51 modifier. This procedure will be whole or full allowable. All other procedures done at the same session are identified by modifier -51. If the secondary procedure(s) require modifier -51 and modifier -51 is not used, the claim will be denied with the message, "756 - must add modifier to CPT/HCPC." Modifier -51 prices the claim at fifty percent of the allowable.

(6) -52 Reduced services - This modifier will be handled like modifier -51. The claim will be paid at 50 percent of the allowable.

(7) -54 Surgical care only - This is applied to the procedure code when the physician performs itinerant surgery or another physician provides the post-operative care. OHCA will pay this at eighty percent of the allowable for the full procedure.

(8) -55 Postoperative management only - When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component is identified by adding the modifier -55 to the usual procedure number. When the surgery is performed by an "itinerant surgeon", and postoperative care is provided by another physician, payment is made for postoperative care under modifier -55 at the rate of 20% of the surgical allowable. When the surgery is cataract surgery performed by an ophthalmologist as an "itinerant surgeon", the postoperative care is paid to the optometrist providing the postoperative care under modifier -55. Payment in this instance will also be made at 20% of the surgical allowable.

(9) -56 Preoperative management only - OHCA will deny payment for this modifier. The physician who provides the preoperative care files under the appropriate medicine codes. A preoperative exam is considered part of the global fee for surgery.

(10) -62 Two surgeons - This modifier is used when two surgeons work as co-surgeons. The code is used when the skills of two surgeons (usually of different specialties) are required in the management of a specific surgical procedure. OHCA will pay this at sixty percent of the allowable for the full procedure. The claims from both surgeons must reflect this modifier.

(11) -66 Surgical team - OHCA will deny payment for this modifier. Each physician must file individually using appropriate modifiers.

(12) -75 Concurrent care - This modifier is used when the member requires the services of two or more physicians. All claims for payment of concurrent care are suspended for medical review. This -75 modifier shows that a specialist is seeing the patient in consultation and rendering a special service or procedure in addition to the services of the admitting physician or primary physician.

(13) -76 Repeat procedure by same physician - This is not to be used for bilateral surgery. When the same physician performs the same procedure two or more times on the same day, the claim is billed showing the procedure code and the number of times it was performed on one line unless the code itself signifies that multiple services were provided. This is particularly important for radiologists, as repeat procedures on the same day may otherwise deny as duplicates. However, if a repeat procedure on same day was omitted on the first filing, a claim is filed with modifier -76. If the claim is for professional component, modifier -26 must be entered as the first modifier and -76 as the second modifier. Alternately, the physician files an adjusted claim showing the correct number of procedures.

(14) -77 Repeat procedure by another physician - This is not to be used for bilateral surgery. This modifier is used when appropriate as it identifies that the claim is not a duplicate of another physician's services. This is especially important for radiologists. If the claim is for professional component, modifier -26 is entered as the first modifier and -77 as the

second modifier.

(15) -78 Return to the operating room for a related procedure during the postoperative period - A procedure with this modifier suspends for physician review to determine appropriate payment.

(16) -79 Unrelated procedure or service by the same physician during the postoperative period - A procedure with this modifier suspends for physician review to determine appropriate payment.

(17) -80 Assistant surgeon:

(A) The assistant surgeon identifies his service by the use of modifier -80 or -82 as appropriate. This modifier is applied to each and every surgical procedure code listed on his claim.

(B) Where there is multiple surgery, the major procedure is followed by -80 and all secondary procedures will have two modifiers: -51, -80. These will follow the procedure code and be on the same line. OHCA will pay modifier -80 at twenty percent of the allowable for the full procedure. All secondary procedures require two modifiers, -51 and -80, and pay ten percent of the allowable for full procedure.

(18) -81 Minimum assistant surgeon - OHCA will deny payment for this modifier.

(19) -82 Assistant surgeon (when qualified resident surgeon not available) - This modifier is used when the claiming physician is the assistant surgeon in a teaching hospital; otherwise, the claim will be denied. OHCA will recognize modifier -82 and pay the modifier at twenty percent of the allowable for the procedure. See modifier -80 for multiple surgery.

(20) -90 Reference (outside) laboratory - OHCA denies payment for this modifier, since the provider performing the procedure must file the claim.

(21) -99 Multiple modifiers - Do not use modifier -99 on the claim. Where two modifiers are required, list the two modifiers on the claim and not the -99 modifier. If modifier -99 is used, OHCA will deny the claim.

(c) **Bilateral surgery.** When a bilateral procedure is performed,

the physician lists the procedure only once on a single line and identifies it as bilateral by modifier -50. Additionally, the narrative description identifies it as bilateral so that the procedure code modifier and the description are compatible. This is true even when one physician does one side and another does the other side. In such instances the appropriate modifiers would be -50, -62. Both follow the procedure code and are on the same line.

(1) Modifier -50 has been developed so that CPT manual may eventually eliminate the use of special procedure codes to identify bilateral procedures and to provide for uniform coding of all bilateral procedures. The CPT manual states: "Use of this modifier will eventually eliminate many of the bilateral procedure numbers now listed separately by five digit codes."

(2) However, if the procedure code states bilateral, do not use the -50 modifier as the allowable has already been calculated as a bilateral procedure. It is extremely important that modifier -50 be applied only to bilateral procedures and not to other multiple surgery procedures. OHCA will suspend all modifier -50 claims for medical review to assure proper payment.

(d) **Multiple surgery.** When a surgeon or assistant surgeon performs multiple surgeries, modifier -51 is applied to secondary procedures. The major procedure must not have modifier -51 applied.

(1) When modifier -51 is used OHCA applies the multiple surgery rule. The multiple surgery rule provides that under certain circumstances the second and subsequent surgeries are paid at a lesser amount. OHCA currently pays procedure codes with modifier -51 at 50 percent of the full allowable for the procedure.

(2) One other issue is, given two or more procedures performed on the same person, on the same day, when does the multiple surgery rule apply? It is important to distinguish between multiple surgery and the multiple surgery rule. Multiple surgery refers to more than one surgical procedure done on the same person on the same day. The multiple surgery rule provides that under certain circumstances the second and subsequent surgeries are paid at a lesser amount.

(A) Some surgeries are never paid under the multiple surgery rule. In other words, they are never compensable when done

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TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

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Rules are revised to allow coverage for first trimester ultrasounds and additional ultrasounds as needed for high risk pregnancies. Through the use of high risk ultrasounds, the provider can more accurately determine the estimated due date which enhances the probability of positive birth outcomes.

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Original signed on 12-18-06

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WF # 06-Y (DT)

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## **INSTRUCTIONS FOR FILING MANUAL MATERIAL**

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following a “DHS” number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The “340” is the Title number that designates DHS as the rulemaking agency; the “2” specifies the Chapter number; and the “1” specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-6392.

### **REMOVE**

317:30-5-2

317:30-5-8

317:30-5-22

317:30-5-24

317:35-3-2

317:45-7-1

### **INSERT**

317:30-5-2, pages 1-12, revised 10-8-06

317:30-5-8, pages 1-11, revised 10-8-06

317:30-5-22, pages 1-3, revised 10-18-06

317:30-5-24, pages 1-2, revised 10-18-06

317:35-3-2, pages 1-3, revised 8-2-06

317:45-7-1, 1 page only, revised 10-8-06

**317:30-5-2. General coverage by category**

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Authority's medical programs, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services may be based on a determination made by the medical consultant in individual circumstances.

(1) Coverages include the following:

(A) Medically appropriate inpatient hospital visits are covered for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgicenter or a Medicare certified hospital that offers outpatient surgical services. Refer to the List of Covered Surgical Procedures.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for member with proven malignancies or opportunistic infections.

(G) Direct physicians' services are covered on an outpatient basis. A maximum payment of four visits are covered per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.

(H) Direct physicians' services in a nursing facility for those members approved for nursing care. Payment is made for a maximum of two nursing facility visits per month. To receive payment for a second nursing facility visit in a

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month denied by Medicare for a Medicare/SoonerCare patient, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Payment is made for medically necessary diagnostic x-ray and laboratory work.

(J) One screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow-up mammograms. This includes interpretation and technical component.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure. Payment is made based upon an invoice for the item.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs under the jurisdiction of the Authority. A copy of the authorization, DHS form ABCDM-16, Authorization for Examination and Billing, must accompany the claim.

(N) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

(O) Family planning - including sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and, with their physician, execute the Federally mandated consent form (ADM-71). A copy of the consent form must be attached to the claim form. Separate payment is made for an I.U.D. inserted during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception are not covered. Reversal of sterilization procedures may be covered when medically indicated and substantiating documentation is attached to the claim. The Norplant System for birth control is covered; however, removal of the Norplant System prior to five years is covered only when

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documented as medically necessary. Reinsertion of Norplant contraceptive will be considered on a case by case basis.

(P) Genetic counseling (requires special medical review prior to approval).

(Q) Blood count weekly for members receiving the drug Clozaril.

(R) Complete blood count and platelet count prior to receiving chemotherapeutic agents or radiation therapy and for members receiving medication such as DPA-D-Penicillamine on a regular basis for treatment other than malignancies.

(S) Payment of ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(T) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with Federal regulations.

(U) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;

(iii) Hold unrestricted license to practice medicine in Oklahoma;

(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;

(v) Seeing members without supervision;

(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;

(vii) Submit billing in own name with appropriate Oklahoma

SoonerCare provider number.

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

(V) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and sign off on the billed encounter;

(ii) Attending physician present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(W) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The member must be at least minimally examined and reviewed by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) This contact must be documented in the medical record.

(X) Payment to a physician for supervision of CRNA services unless the CRNA bills directly.

(Y) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

(Z) Organ and tissue transplantation services for children and adults, limited to bone marrow, stem cells, cornea, heart, kidney, liver, lung, SPK (simultaneous pancreas

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kidney), PAK (pancreas after kidney), and heart-lung, are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

(i) All transplantation services, except kidney and cornea, must be prior authorized to be compensable.

(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(iii) To be compensable under the SoonerCare program all organ transplants must be performed at a Medicare approved transplantation center.

(iv) Finally, procedures considered experimental or investigational are not covered.

(AA) Total parenteral nutritional therapy for certain diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(EE) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the patient to describe their smoking use;

(II) Advising the patient to quit;

(III) Assessing the willingness of the patient to quit;

(IV) Assisting the patient with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP capitation payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note and signature along with the patient specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(2) General exclusions include the following:

(A) Inpatient diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the codes for subsequent hospital care should

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be used.

(D) Refractions and visual aids.

(E) A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of persons who are under 21 years of age, mentally incompetent or institutionalized. Reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomy.

(I) Medical services considered to be experimental or investigational.

(J) Payment for more than four outpatient visits per month (home or office) per member except those visits in connection with family planning, or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

(M) Physician supervision of hemodialysis or peritoneal dialysis.

(N) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(P) Payment for the services of physicians' assistants, social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out.

(Q) Induced abortions, except when certified in writing by a

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physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (See OAC 317:30-5-6 or 317:30-5-50.)

(R) Night calls or unusual hours.

(S) Speech and Hearing services.

(T) Mileage.

(U) Other than routine hospital visit on date of discharge unless member expired.

(V) Direct payment to perfusionist as this is considered part of the hospital cost.

(W) Inpatient chemical dependency treatment.

(X) Fertility treatment.

(Y) Routine immunizations.

(Z) Payment for removal of benign skin lesions unless medically necessary.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's medical programs, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for patients under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services will be prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(A) Effective October 1, 1993, all residential and acute psychiatric services will be authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25.

(B) Out of state placements will not be authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the state, treatment for medical services will be covered in the same way as they would be covered within the state. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options.

(A) Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation which validates the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.25. Requests shall be made prior to the expiration of the approved inpatient stay.

(B) All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** SoonerCare utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment**

**program.** Payment is also made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Title 21, Oklahoma Statutes, Section 846, as amended, states in part: *Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of eighteen (18) years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of eighteen (18) years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above. Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought as a result of the report.*

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient

consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the codes for subsequent hospital care should be used.

(D) A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of persons who are under 21 years of age.

(G) Non-therapeutic hysterectomy.

(H) Medical Services considered to be experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (See OAC 317:30-5-6 or 317:30-5-50.)

(K) Physician supervision of hemodialysis or peritoneal dialysis.

(L) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(M) Payment for the services of physicians' assistants except as specifically set out.

(N) Direct payment to perfusionist as this is considered part of the hospital cost.

(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(P) Night calls or unusual hours.

(Q) Mileage.

(R) Other than routine hospital visit on date of discharge unless patient expired.

(S) Tympanometry.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. For in-State physicians, claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits will reflect a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with SoonerCare within 90 days of the date of Medicare payment in order to be considered timely filed. The Medicare EOMB must be attached to the claim. If payment was denied by Medicare Part B, and the service is a SoonerCare covered service, mark the claim "denied by Medicare".

(1) Out of state claims will not "cross over". Providers must file a claim for coinsurance and/or deductible within 90 days of the Medicare payment. The Medicare EOMB must be attached to the claim.

(2) Claims filed under SoonerCare must be filed within one year from the date of service. For dually eligible members, to be eligible for payment of coinsurance and/or deductible under SoonerCare, a claim must be filed with Medicare within one year from the date of service.

**317:30-5-8. Surgery**

(a) **Use of surgical modifiers.** The Physicians' Current Procedural Terminology (CPT) provides for 2-digit surgical modifiers to further describe surgical services. All of these modifiers must be used on OHCA claims when applicable. The CPT also provides an alternate method of using a special 5-digit code beginning with 099--. These codes will not be accepted by OHCA. This method cannot be used to record modifications to the procedure code. Use the appropriate 2-digit modifier placed just to the right of the 5-digit surgical procedure code.

(b) **Description of modifiers and how they are paid.**

(1) -20 Microsurgery - OHCA does not make an additional payment for this modifier. The procedure will be paid at the regular OHCA allowable.

(2) -22 Unusual services - OHCA does not make an additional payment for this modifier. The procedure will be paid at the regular OHCA allowable.

(3) -26 Professional component - This modifier is used to identify a professional component. It is used when the physician provides an interpretation rather than a full-service procedure. Modifier -26 will also be used by the hospital-based radiologist or pathologist on radiology, surgical pathology and echocardiography done in the hospital. The allowables for modifier -26 are listed in the Authority's listing of the procedure-based maximum allowable payments.

(4) -47 Anesthesia by surgeon - OHCA does not make an additional payment for this modifier. OHCA does not make an additional payment for local anesthesia. OHCA will pay additional for surgical procedure codes 62274 through 62279 and nerve block, codes 64400 through 64530. These codes are used by surgeons or obstetricians when applicable without modifier -47. The procedure will be paid at the regular OHCA allowable. Anesthesia coding and methodology is described at the front of the CPT for the practicing anesthesiologist.

(5) -50 Bilateral procedure and - 51 Multiple surgery - There has been some misunderstanding about the use of modifier -50 (bilateral surgery) and -51 (multiple surgery). These modifiers are not interchangeable. They have very different meanings and

result in very different payments.

(A) Bilateral Procedure. This modifier is to be used when there is no specific code in the CPT for a bilateral procedure. List the bilateral procedure on one line followed by modifier -50. The payment will be 150 percent of the base allowable for the procedure so it is no longer necessary to list the procedure twice on a claim when it is bilateral. The units of service are shown as "1".

(B) Multiple surgery. When a surgeon or assistant surgeon performs multiple surgery, modifier -51 is applied to the secondary procedures. The multiple surgery rule provides that the second and subsequent surgeries are paid at a lesser amount. The major procedure is listed without a -51 modifier. This procedure will be whole or full allowable. All other procedures done at the same session are identified by modifier -51. If the secondary procedure(s) require modifier -51 and modifier -51 is not used, the claim will be denied with the message, "756 - must add modifier to CPT/HCPC." Modifier -51 prices the claim at fifty percent of the allowable.

(6) -52 Reduced services - This modifier will be handled like modifier -51. The claim will be paid at 50 percent of the allowable.

(7) -54 Surgical care only - This is applied to the procedure code when the physician performs itinerant surgery or another physician provides the post-operative care. OHCA will pay this at eighty percent of the allowable for the full procedure.

(8) -55 Postoperative management only - When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component is identified by adding the modifier -55 to the usual procedure number. When the surgery is performed by an "itinerant surgeon", and postoperative care is provided by another physician, payment is made for postoperative care under modifier -55 at the rate of 20% of the surgical allowable. When the surgery is cataract surgery performed by an ophthalmologist as an "itinerant surgeon", the postoperative care is paid to the optometrist providing the postoperative care under modifier -55. Payment in this instance will also be made at 20% of the surgical allowable.

(9) -56 Preoperative management only - OHCA will deny payment for this modifier. The physician who provides the preoperative care files under the appropriate medicine codes. A preoperative exam is considered part of the global fee for surgery.

(10) -62 Two surgeons - This modifier is used when two surgeons work as co-surgeons. The code is used when the skills of two surgeons (usually of different specialties) are required in the management of a specific surgical procedure. OHCA will pay this at sixty percent of the allowable for the full procedure. The claims from both surgeons must reflect this modifier.

(11) -66 Surgical team - OHCA will deny payment for this modifier. Each physician must file individually using appropriate modifiers.

(12) -75 Concurrent care - This modifier is used when the member requires the services of two or more physicians. All claims for payment of concurrent care are suspended for medical review. This -75 modifier shows that a specialist is seeing the patient in consultation and rendering a special service or procedure in addition to the services of the admitting physician or primary physician.

(13) -76 Repeat procedure by same physician - This is not to be used for bilateral surgery. When the same physician performs the same procedure two or more times on the same day, the claim is billed showing the procedure code and the number of times it was performed on one line unless the code itself signifies that multiple services were provided. This is particularly important for radiologists, as repeat procedures on the same day may otherwise deny as duplicates. However, if a repeat procedure on same day was omitted on the first filing, a claim is filed with modifier -76. If the claim is for professional component, modifier -26 must be entered as the first modifier and -76 as the second modifier. Alternately, the physician files an adjusted claim showing the correct number of procedures.

(14) -77 Repeat procedure by another physician - This is not to be used for bilateral surgery. This modifier is used when appropriate as it identifies that the claim is not a duplicate of another physician's services. This is especially important for radiologists. If the claim is for professional component, modifier -26 is entered as the first modifier and -77 as the

second modifier.

(15) -78 Return to the operating room for a related procedure during the postoperative period - A procedure with this modifier suspends for physician review to determine appropriate payment.

(16) -79 Unrelated procedure or service by the same physician during the postoperative period - A procedure with this modifier suspends for physician review to determine appropriate payment.

(17) -80 Assistant surgeon:

(A) The assistant surgeon identifies his service by the use of modifier -80 or -82 as appropriate. This modifier is applied to each and every surgical procedure code listed on his claim.

(B) Where there is multiple surgery, the major procedure is followed by -80 and all secondary procedures will have two modifiers: -51, -80. These will follow the procedure code and be on the same line. OHCA will pay modifier -80 at twenty percent of the allowable for the full procedure. All secondary procedures require two modifiers, -51 and -80, and pay ten percent of the allowable for full procedure.

(18) -81 Minimum assistant surgeon - OHCA will deny payment for this modifier.

(19) -82 Assistant surgeon (when qualified resident surgeon not available) - This modifier is used when the claiming physician is the assistant surgeon in a teaching hospital; otherwise, the claim will be denied. OHCA will recognize modifier -82 and pay the modifier at twenty percent of the allowable for the procedure. See modifier -80 for multiple surgery.

(20) -90 Reference (outside) laboratory - OHCA denies payment for this modifier, since the provider performing the procedure must file the claim.

(21) -99 Multiple modifiers - Do not use modifier -99 on the claim. Where two modifiers are required, list the two modifiers on the claim and not the -99 modifier. If modifier -99 is used, OHCA will deny the claim.

(c) **Bilateral surgery.** When a bilateral procedure is performed,

the physician lists the procedure only once on a single line and identifies it as bilateral by modifier -50. Additionally, the narrative description identifies it as bilateral so that the procedure code modifier and the description are compatible. This is true even when one physician does one side and another does the other side. In such instances the appropriate modifiers would be -50, -62. Both follow the procedure code and are on the same line.

(1) Modifier -50 has been developed so that CPT manual may eventually eliminate the use of special procedure codes to identify bilateral procedures and to provide for uniform coding of all bilateral procedures. The CPT manual states: "Use of this modifier will eventually eliminate many of the bilateral procedure numbers now listed separately by five digit codes."

(2) However, if the procedure code states bilateral, do not use the -50 modifier as the allowable has already been calculated as a bilateral procedure. It is extremely important that modifier -50 be applied only to bilateral procedures and not to other multiple surgery procedures. OHCA will suspend all modifier -50 claims for medical review to assure proper payment.

(d) **Multiple surgery.** When a surgeon or assistant surgeon performs multiple surgeries, modifier -51 is applied to secondary procedures. The major procedure must not have modifier -51 applied.

(1) When modifier -51 is used OHCA applies the multiple surgery rule. The multiple surgery rule provides that under certain circumstances the second and subsequent surgeries are paid at a lesser amount. OHCA currently pays procedure codes with modifier -51 at 50 percent of the full allowable for the procedure.

(2) One other issue is, given two or more procedures performed on the same person, on the same day, when does the multiple surgery rule apply? It is important to distinguish between multiple surgery and the multiple surgery rule. Multiple surgery refers to more than one surgical procedure done on the same person on the same day. The multiple surgery rule provides that under certain circumstances the second and subsequent surgeries are paid at a lesser amount.

(A) Some surgeries are never paid under the multiple surgery rule. In other words, they are never compensable when done

in conjunction with other surgeries; payment is made only for the major procedure. Examples are exploratory laparotomy, lysis of adhesions or appendectomy for staging done in conjunction with other abdominal surgery. These procedures are always incidental to the major procedure.

(B) There are many surgeries which always include lesser surgeries. For example, a TUR always includes a cystoscopy; bronchoscopy always includes laryngoscopy. Payment for vaginal delivery always includes payment for any cervical block, episiotomy or episiotomy repair or pudendal block.

(C) Some surgeries do not contribute significantly to the difficulty of a major surgical procedure. These surgeries are denied because they do not represent any significant additional time or effort. An example is liver biopsy during other abdominal surgery.

(D) Some procedures, although multiple, have single codes which combine the procedures. For example, a skin graft to an area may include obtaining the graft from a different area and an arthrodesis code may specify that it includes obtaining the bone graft.

(E) Bilateral multiple surgery using modifier -50 is usually subject to the multiple surgery rule so that modifier -50, followed by -51 may be necessary for a bilateral secondary procedure. The result will be that an allowable of 150 percent is cut in half, or 75 percent of the basic allowable.

(F) Some multiple surgeries are properly treated as co-surgery under a single procedure code. For instance, a neurosurgeon and orthopedist may work together on a laminectomy with arthrodesis (single procedure code) or a neurosurgeon and ENT surgeon may work together on a transnasal surgery on the pituitary gland. Co-surgery is billed using modifier -62.

(3) There are two special procedure codes which may be used when microdissection is involved:

(A) 64830. Microdissection and/or repair of nerve. This code is listed on the next claim line immediately below the nerve repair and the allowable is 50 percent of the allowable for the repair itself.