



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Surgical Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: July 12, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: April 6, 2017	CoreMMIS update	FSSA and HPE
2.0	Policies and procedures as of May 1, 2017 Published: August 22, 2017	Scheduled update: <ul style="list-style-type: none"> • Reorganized and edited text as needed for clarity • Removed unneeded information from the Coverage and Reimbursement section • Clarified that information in the Multiple Procedures and Bilateral Procedures sections is specific to professional billing • Renamed and updated the Facility Charges for Outpatient Surgeries section and its Multiple Surgeries and Bilateral Procedures subsection • Updated the Bariatric Surgery section, including removing the ICD-9 code and updating information about noncovered procedures for minors • Updated the Implantable DME section, including adding <i>Table 7 – Separate Reimbursement for Devices Implanted in an Outpatient Setting</i> • Replaced specific medical criteria in applicable subsections of the Implantable DME section with a reference to the <i>Medical Policy Manual</i> 	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> • Updated the Implantable Cardioverter Defibrillators section, including adding references to subcutaneous ICDs and to FDA approval • Removed extraneous information from the Implantable Infusion Pumps section • Added PA requirement to the Osteogenic Bone Growth Stimulators section • Updated the reimbursement rate in the Pacemakers section, and added PA and managed care referral requirements • Updated the Phrenic Nerve Stimulator (Breathing Pacemaker) section and subsections, including updating general coverage requirements, correcting inpatient reimbursement information, and removing the <i>Device Monitoring</i> subsection • Added information about transcatheter placement of intravascular stents to the Stents section 	

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Surgical Services

Note: For policy information regarding coverage of surgical services, see the [Medical Policy Manual](#) at indianamedicaid.com.

Introduction

The Indiana Health Coverage Programs (IHCP) provides coverage for inpatient and outpatient surgical services and associated implantable medical equipment within the guidelines described in this document.

For information on surgical supplies, see the [Durable and Home Medical Equipment and Supplies](#) module.

Note: For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, providers must contact the appropriate managed care entity (MCE) for specific policies and procedures. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at indianamedicaid.com.

Prior Authorization

Prior authorization (PA) for surgical services provided to IHCP fee-for-service members must be requested from Cooperative Managed Care Services (CMCS). Members enrolled in a managed care program, such as HIP, Hoosier Care Connect, or Hoosier Healthwise, must be prior authorized by the MCE in accordance with the MCE guidelines.

PA is required for all procedures outlined in *Indiana Administrative Code 405 IAC 5-3-13*. Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient, must be prior authorized. The length of stay for the inpatient admission is determined by the appropriate diagnosis-related group (DRG), but is subject to retrospective review for medical necessity. Criteria for determining the medical necessity for inpatient admission include the following:

- Technical or medical difficulty during the outpatient procedure, as documented in the medical record
- Presence of physical or mental conditions that make prolonged preoperative or postoperative observations by a nurse or other skilled medical personnel a necessity
- Simultaneous performance of another procedure, which itself requires hospitalization
- Likelihood of another procedure that would require hospitalization following the initial procedure

See the [Prior Authorization](#) module for additional information on requesting PA.

Coverage and Reimbursement

A surgical procedure generally includes the preoperative visits performed on the same day as or the day before the surgery for major surgical procedures, and the day of the surgical procedure for minor surgical procedures. Separate reimbursement is available for preoperative care when the provider performing the surgery has never seen the patient, or when the decision to perform surgery was made during the preoperative visit. Modifier 57 – *Decision for surgery* must be submitted on the *CMS-1500* claim form or its electronic equivalent (837P transaction or Provider Healthcare Portal professional claim) with the evaluation and management (E/M) procedure code to indicate that the E/M service resulted in the initial decision to perform surgery. Preoperative visits performed on the same day as a surgical procedure may

also be separately reimbursed if the patient is seen for evaluation of a separate clinical condition; see the [Evaluation and Management Services](#) module for details.

The postoperative care days for a surgical procedure include 90 days following a major surgical procedure and 10 days following a minor surgical procedure. Separate reimbursement is available during the global postoperative period for care that is unrelated to the surgical procedure, for care not considered routine, and for postoperative care for surgical complications.

If the patient's condition requires additional medical or surgical care outside the scope of the operating surgeon – for example, an additional surgery performed by a different specialist for a different diagnosis – on the same day, reimbursement for the medical care is considered individually.

Medical Visits for Surgical Complications

Medical visits for surgical complication are reimbursed only if medically indicated and no other physician has billed for the same or related diagnosis. The claim must indicate the specific complications, and providers should attach documentation that clearly supports the medical necessity for the care provided. The medical visits are billed separately from the surgical fee. Such complications may include but are not limited to the following:

- Cardiovascular complications
- Comatose conditions
- Elevated temperature above 38.4 degrees Celsius, 101 degrees Fahrenheit, for two or more consecutive days
- Medical complications, other than nausea and vomiting, due to anesthesia
- Nausea and vomiting persisting more than 24 hours
- Postoperative wound infection requiring specialized treatment
- Renal failure

Provider Preventable Conditions

The IHCP follows the Centers for Medicare & Medicaid Services (CMS) rule and does not cover surgical or other invasive procedures to treat particular medical conditions when the practitioner performs the surgery or invasive procedure erroneously, including:

- Incorrect surgical or other invasive procedures
- Surgical or other invasive procedures on the wrong body part
- Surgical or other invasive procedures on the wrong patient

The IHCP also does not cover hospitalizations or other services related to these noncovered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, that could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

The IHCP will deny payments to providers for inpatient, inpatient crossover, inpatient crossover Medicare Replacement Plan, outpatient, outpatient crossover, outpatient crossover Medicare Replacement Plan, physician, physician crossover, and physician crossover Medicare Replacement Plan claims when provider preventable conditions (PPC) are performed on a patient. See *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com for a list of PPC diagnosis codes. Providers may not bill the member for PPCs or related services upon denial of reimbursement by the IHCP.

The following PPC modifiers must be submitted on physician, physician crossover, and physician crossover Medicare Replacement Plan claims indicating errors:

- PA – *Surgery wrong body part*
- PB – *Surgery wrong patient*
- PC – *Wrong surgery on patient*

Multiple Procedures

When two or more covered surgical procedures are performed during the same operative session, multiple surgery reductions apply to the procedures. For multiple surgical procedures billed on the professional claim (CMS-1500 claim form or electronic equivalent), the following adjustments apply:

- 100% of the global fee for the most expensive procedure
- 50% of the global fee for the second most expensive procedure
- 25% of the global fee for the remaining procedures

All surgeries that are performed on the same day, by the same rendering physician, must be billed on the same professional claim form. Otherwise, the claim may be denied, and the original claim must be adjusted for any additional payment.

For information about the outpatient facility reimbursement methodology for multiple surgical procedures, see the [Facility Charges for Outpatient Surgeries](#) section.

Bilateral Procedures

Bilateral surgery procedures are those performed on both sides of the body, during the same operative episode by the same provider. Effective February 13, 2017, the IHCP applies Centers for Medicare & Medicaid Services (CMS) guidelines for professional reimbursement of bilateral procedures. Reimbursement for the procedure codes is based on the CMS Medicare Physician Fee Schedule relative value file status indicators, as shown in the following table.

Table 1 – Medicare Physician Fee Schedule Relative Value File Status Indicators

Indicator	Description
0	150% payment adjustment for bilateral procedures does not apply. Reimbursement is based on the lesser of the billed amount or the allowed amount.
1	150% payment adjustment for bilateral procedures applies. Reimbursement is based on the lesser of the billed amount or 150% of the allowed amount.
2	150% payment adjustment does not apply. The procedure is inherently bilateral and the reimbursement rate already includes payment for both sides. Reimbursement is based on the lesser of the billed amount or the allowed amount.
3	The usual payment adjustment for bilateral procedures does not apply. Reimbursement is based on the lesser of the billed amount or the allowed amount for each side.
9	Concept does not apply. Services performed with modifier 50 will be systematically denied.

Providers submitting claims using modifier 50, indicating bilateral procedure, must enter only one unit in field 24G on the *CMS-1500* claim form or in the corresponding field of the electronic professional claim. The use of modifier 50 ensures that the procedure code is priced according to the indicator description in Table 1. Providers should note that, if the Current Procedural Terminology (CPT®¹) code description specifies the procedure as bilateral, modifier 50 must *not* be used on the claim.

The explanations of benefits (EOBs) associated with modifier 50 in *CoreMMIS* are as follows:

- EOB 4401 – *Modifier 50 “Bilateral” is invalid for the procedure billed. Please correct and resubmit.*
- EOB 6426 – *Modifiers 50, RT, and LT, which were billed for this service, are not billable together. Please correct and resubmit.*

For information about the outpatient facility reimbursement methodology for bilateral procedures, see the [Facility Charges for Outpatient Surgeries](#) section.

Cosurgeons

Cosurgeons must append modifier 62 to the surgical service. Modifier 62 cuts the reimbursement rate to 62.5% of the rate on file.

Assistant Surgeons

A surgeon may be requested to assist the performing surgeon as an assistant surgeon during a complex surgical procedure. Documentation explaining the need for an assistant should accompany the claim and modifier 80 must be used.

Reimbursement for surgical assistant is limited to the procedures that generally require the skills and services of an assistant surgeon, as set out in the Healthcare Common Procedure Coding System (HCPCS). If extenuating circumstances require an assistant surgeon when customarily one is not required, the circumstances must be well documented in the hospital record and documentation must be attached to the claim form. Reimbursement is not available for a surgical assistant who assists in diagnostic surgical procedures or for minor surgical procedures.

Split Care

The IHCP requires a written agreement when a global surgical procedure is split among multiple providers. The conditions are the same as those for Medicare and are illustrated as follows:

- Providers billing for split care must have a written agreement outlining the date care is to be turned over and the name of the provider receiving the patient.
- The agreement must become part of the patient’s file.
- The agreement must be submitted with any review or hearing request about the split-care payment.
- Modifiers 54 and 55 must be used if a written agreement exists.
- Physician must bill the appropriate CPT code without modifier 54 or 55 if a written agreement does not exist.

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Split-Care Billing Procedures and Reimbursement Calculation

When the provider that performed the surgery does not provide any postoperative care, the provider must bill the surgical procedure code with modifier 54 – *Surgical care only* and the actual date of the surgery.

If the primary care physician is rendering the preoperative or postoperative care only, this information and the name and address of the operating physician must be indicated on the claim form.

Postoperative care must be billed using the surgical procedure code with modifier 55 – *Postoperative management only*. The dates of service must reflect the date care was assumed and relinquished, and the units field must include the total number of postoperative days furnished. To ensure appropriate reimbursement when billing with modifier 55, the number of days within the date of service range must equal the number of units (days) reported on the claim. For the purposes of defining postoperative care units, one unit is equal to one day of postoperative care.

Note: The postoperative period begins the day after surgery.

Postoperative management claims must not be submitted until the physician managing the postoperative care sees the patient for the first time.

The following two examples define appropriate billing procedures for split care and show how reimbursement is calculated. The examples use procedure code 43030, a 90-day postoperative period, and allow a total of \$460.48 for the global service, as shown in Table 2.

Table 2 – Procedure Code 43030

Description	Percentage	Modifier
Preoperative	9	
Intraoperative	+81	
Total intraoperative	90	54
Postoperative	10	55
Total	100	

Example 1

In this example, two physicians split the postoperative care. Physician A performs the surgical procedure and manages the patient postoperatively for 60 days, as shown in Table 3.

Table 3 – Billing Physician A

Physician A	From Date of Service	To Date of Service	Procedure Code	Modifier	Units Billed
Detail 1	10/01/2016	10/01/2016	43030	54	1
Detail 2	10/02/2016	11/30/2016	43030	55	60

Calculations are made as follows:

Detail 1: Global fee of \$460.48 multiplied by 0.90 (9% preoperative percentage + 81% intraoperative percentage) multiplied by 1 unit billed equals \$414.43.

Detail 2: Global fee of \$460.48 multiplied by 0.10 equals the total postoperative allowance of \$46.048 divided by 90 (number of global days assigned) equals \$0.5116 per day multiplied by 60 (number of postoperative days reported) equals \$30.699 or \$30.70.

As shown in Table 4, Physician B performs the balance of the postoperative care for 30 days.

Table 4 – Billing Physician B

Physician B	From Date of Service	To Date of Service	Procedure Code	Modifier	Units Billed
Detail 1	12/01/2016	12/30/2016	43030	55	30

Calculations are made as follows:

Detail 1: Global fee of \$460.48 multiplied by 0.10 equals the total postoperative allowance of \$46.048 divided by 90 (number of global days assigned) equals \$0.5116 per day multiplied by 30 (number of postoperative days reported) equals \$15.348 or \$15.35. When only one provider is responsible for the surgery and all the postoperative care, the provider must bill the surgical procedure, without modifier 54 or 55. The IHCP-allowed amount in this case would be 100% of the resource-based relative value scale (RBRVS) fee.

Note: Modifiers 54 and 55 are used only to split postoperative care between multiple providers.

Example 2

In this example, the same provider bills for the surgery and all the postoperative care. Physician A performs and bills for the surgical procedure and all the postoperative care, as shown in Table 5.

Table 5 – Billing Physician A

Physician A	From Date of Service	To Date of Service	Procedure Code	Modifier	Units Billed
Detail 1	10/01/2016	10/01/2016	43030		1

Calculations are made as follows:

The global fee for procedure code 43030 is \$460.48. Therefore, reimbursement for this service should be made at \$460.48.

Exceptions and Special Billing Considerations

If more than one physician in the same group practice participates in a portion of a patient's care, included in a global surgery package, only the physician who performs the surgery can submit a bill. Split-care modifiers are not applicable, and the surgeon's claim must include only the surgical procedure. Although other physicians participated in the care, all are within the same group practice. There is no need to split the reimbursement because the physician group is reimbursed the global fee.

If a transfer of care does not occur, occasional postdischarge services for a physician other than the surgeon are reported with the appropriate E/M code. Modifiers are not required.

If the transfer of care occurs immediately after surgery, the physician who provides the postoperative care while the patient remains in the hospital bills using subsequent hospital care codes. After the patient is released from the hospital, the physician responsible for postoperative care must bill using the surgical procedure code with modifier 55. The surgeon must bill the appropriate surgical procedure code with modifier 54.

If a physician provides follow-up services during the postoperative period for minor procedures performed in the emergency department, the physician must bill the appropriate level of office visit code. The emergency department physician who performed the surgical service must bill the surgical procedure code without a modifier.

If the services of a physician, other than the surgeon, are required during a postoperative period for an underlying condition or medical complication, the other physician must report the appropriate E/M code, and split-care modifiers are not required on the claim. For example, a cardiologist may manage the underlying cardiovascular condition during the postoperative period for a cardiovascular procedure that was performed by a cardiothoracic surgeon.

If a patient is returned to surgery for a related procedure during the postoperative period, the procedure must be billed using modifier 78. In this situation, the IHCP-allowed amount is calculated by multiplying the RBRVS fee amount by the surgical care only (intraoperative) percentage on the Medicare fee schedule data base (MFSDB). In these situations, the preoperative percentage is not added to the intraoperative percentage for calculating the allowed amount described in the first example. In addition, a new postoperative period is not allowed for the related procedure. The number of postoperative days allowed following the return to surgery is equal to the number of postoperative days remaining from the original procedure.

Billing certain modifiers on the same detail is restricted as follows to avoid processing issues:

- Modifier 54 – *Surgical care only* cannot be billed on the same detail as modifiers 55, 78, 80, 81, 82, AA, AS, P1–P5, QX, or QZ, or the detail denies for an invalid modifier combination.
- Modifier 55 – *Postoperative management only* cannot be billed on the same detail as modifiers 54, 78, 80, 81, 82, AA, AS, P1–P5, QJ, QK, QX, or QZ, or the detail denies for an invalid modifier combination.

Facility Charges for Outpatient Surgeries

The IHCP reimburses facility charges for outpatient surgeries at an all-inclusive rate that includes reimbursement for related procedures. The outpatient surgery procedures are classified into an IHCP ambulatory surgical center (ASC) group that is closest to, without exceeding, Medicare's outpatient prospective payment system fee schedule amount. All services are included in the all-inclusive reimbursement rate.

Providers can obtain rate information and ASC assignment codes related to specific procedure codes on the Outpatient Fee Schedule. The ASC Code/Rate table lists all ASC assignment codes, effective dates, and pricing. Both the Outpatient Fee Schedule and the ASC Code/Rate table are available from the [IHCP Fee Schedules](#) page at indianamedicaid.com.

For more information about outpatient billing, see the [Outpatient Hospital and Ambulatory Surgical Center Services](#) module.

Surgical Revenue Codes

Surgical revenue codes are generally defined as 36X and 49X. The revenue codes for treatment rooms, such as 45X, 51X, 52X, 70X, 72X, and 76X, are defined as surgical revenue codes when accompanied by a surgical CPT or HCPCS code. The IHCP reimburses these revenue codes at the appropriate ASC rate. If the provider performs no surgical procedure, the provider may submit the revenue code without a CPT or HCPCS code. The IHCP reimburses these services at the treatment room rate.

Providers combine all charges and services associated with the surgical procedure as an all-inclusive charge on one line item. Component billing of any related services is not appropriate and is denied.

Note: The IHCP does not allow add-on or stand-alone services with any surgical revenue codes.

Providers must bill outpatient surgeries provided in a hospital or an ASC on a *UB-04* claim form or its electronic equivalent (837I transaction or Provider Healthcare Portal institutional claim type).

The appropriate surgical procedure code must accompany one of the revenue codes listed in Table 6. Providers must include all outpatient services provided on the day of the surgery on a single claim.

Table 6 – Surgical Revenue Codes

Revenue Code	Description
36X	Operating room services
45X	Emergency department
49X	Ambulatory surgical care
51X	Clinic
52X	Freestanding clinic
70X	Cast room
72X	Labor/delivery room
76X	Treatment/observation room

Multiple Surgeries and Bilateral Procedures

To denote multiple surgeries, the provider must list each appropriate revenue code and procedure code as separate detail line items on the claim form.

For outpatient billing, a maximum of two separate surgical procedures is reimbursable per day when performed in the same facility. When multiple surgical procedures are performed within the same incision, the IHCP pays the procedure with the highest ASC rate at 100% of that rate. The procedure with the second highest ASC rate is reimbursed at 50% of its ASC rate. Additional procedures performed on the same day in the same facility are not reimbursed.

The maximum IHCP reimbursement for each surgical procedure is two units of service to accommodate bilateral procedures. As described in the [Bilateral Procedures](#) section of this document, bilateral surgical procedures are generally reimbursed at 150% of the allowed amount: One unit is paid at 100% of the ASC rate, and the second unit is reimbursed at 50% of the ASC rate. Additional units are denied. Bilateral surgeries reimbursed at 150% of the ASC are considered two separate procedures; therefore, no additional procedures are reimbursed for that surgery.

Procedures billed with modifier 50 indicate a procedure that has been performed bilaterally. Bilateral procedures billed with a modifier of 50 must not be billed with units greater than 1. Specific bilateral procedures (conditionally bilateral and independently bilateral) that are billed with a quantity greater than 1 are denied.

Anesthesia and Surgery

The IHCP reimburses local anesthesia (therapeutic or regional blocks) as a surgical procedure. Time units or modifying factors associated with local anesthesia are not reimbursable. For additional information, see the [Anesthesia Services](#) module.

Reimbursement for anesthesia administered by the surgeon in conjunction with a surgical procedure is included in the fee for the surgical procedure.

Stereotactic Radiosurgery

The IHCP currently covers several types of stereotactic radiosurgery (SRS), as represented by HCPCS codes G0339, G0340, and 77301 U5. In addition, the IHCP covers preoperative planning under HCPCS code 77301 U5. Reimbursement for physician services is bundled into the preoperative planning service.

Bariatric Surgery

Bariatric surgery is recognized as medically necessary when used for the treatment of morbid obesity. The IHCP provides reimbursement for the bariatric procedures described in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com. Providers must report ICD-10 diagnosis code E66.01 – *Morbid obesity* with the most specific procedure code available that represents the procedure performed. Procedures that are considered investigational or not meeting safety or efficacy standards will not be covered. For children under the age of 18, laparoscopic adjustable gastric banding (LAGB) is considered investigational and is not covered.

All types of bariatric surgery, as well as surgical procedures performed to correct or revise the initial surgical procedure, require PA and are subject to the conditions and documentation requirements outlined in the [Medical Policy Manual](#). Within the managed care delivery system, individual MCEs establish and publish coverage criteria, PA, and billing requirements. For members enrolled in HIP, Hoosier Healthwise, or Hoosier Care Connect, providers should contact the member's MCE for specific criteria and requirements.

PA is not required for HCPCS procedure code S2083 – *Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline*. This procedure is considered a routine, frequently performed, office procedure; it is not a surgical procedure. However, the IHCP does not provide reimbursement for HCPCS code S2083 during the 90-day global period for procedure codes 43770, 43771, 43773, 43886, and 43888, because adjustment is already included in the 90-day global period reimbursement for these services.

Implantable DME

For certain implantable durable medical equipment (DME), the cost of the device is separately reimbursable, in addition to the outpatient hospital claim for the implantation procedure. See [Table 7](#). The facility provider should submit claims for these items, and only these items, on the professional claim (*CMS-1500* claim form or electronic equivalent). The IHCP permits only these items to have separate reimbursement.

Providers should carefully review the following sections for information about whether an implantable device is separately reimbursable, as well as for PA requirements and billing guidance.

Table 7 – Separate Reimbursement for Devices Implanted in an Outpatient Setting

Device	Separately Reimbursed?
Implantable cardioverter defibrillator	Yes
Implantable infusion pump	Yes
Osteogenic Bone Growth Stimulator (implantable)	Yes
Pacemakers	Yes
Patient-Activated Event Recorder – Implantable Loop Recorder	Yes
Phrenic Nerve Stimulator	Yes
Spinal Cord Stimulator	Yes
Stent	No

Device	Separately Reimbursed?
Transcatheter Aortic Valve Replacement/Implantation	No
Vagus Nerve Stimulator	Yes
Ventricular Assist Devices	N/A

Implantable Cardioverter Defibrillators

The IHCP covers implantable cardioverter defibrillator devices including, for dates of service on or after July 1, 2016, subcutaneous implantable cardioverter defibrillators (S-ICDs). Prior authorization is required for all implantable cardioverter defibrillators. The planned implantable cardioverter defibrillator must have received full market approval from the Food and Drug Administration (FDA). Specific medical criteria for coverage, as well as disqualifying criteria, appear in the [Medical Policy Manual](#).

The IHCP reimburses the cost of the implantable cardioverter defibrillator device separately from the implantation procedure when the implantation is performed in an outpatient surgical setting. Providers must bill the device on a professional claim (*CMS-1500* claim form or electronic equivalent), using the implantable cardioverter defibrillator procedure codes listed in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

An itemized cost invoice must be submitted with the claim for the device. The invoice can be submitted by mail, either as an attachment behind the paper claim form or with a cover letter and Claim ID corresponding to an electronic claim submission, or it may be uploaded electronically along with claims submitted via the Provider Healthcare Portal. See the [Claim Submission and Processing](#) module and the [Provider Healthcare Portal](#) module for details.

Implantable Infusion Pumps

Implantable infusion pumps are supplied as a complete system with all the necessary components and may be either programmable or nonprogrammable. PA is not required for the implantable device or services. Implantable devices for intra-arterial, epidural, and intrathecal infusions are considered medically appropriate, based on the criteria listed in the [Medical Policy Manual](#).

Providers must submit claims for procedure codes for the nonprogrammable pump (E0782) and the programmable pump (E0783) on the professional claim (*CMS-1500* claim form or electronic equivalent). For related surgical and electronic analysis codes, see *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

Osteogenic Bone Growth Stimulators

The IHCP covers four types of osteogenic bone-growth stimulators (OBGS), including invasive or implantable stimulators (E0749). Prior authorization is required. See the [Durable and Home Medical Equipment and Supplies](#) module for more information.

Pacemakers

IHCP reimbursement is available for implantation of cardiac pacemakers and monitoring when the service is provided in compliance with all IHCP guidelines, including obtaining PA and appropriate referrals for members enrolled in managed care programs. Providers must bill using the appropriate procedure code in addition to the IICD diagnosis code to the highest level of specificity that supports medical necessity.

When cardiac pacemaker implantation is performed in an outpatient surgical setting, the IHCP reimburses the cost of single-chamber pacemakers, dual-chamber pacemakers, and other pacemakers separately, in addition to the ASC rate. The facility purchasing the pacemaker must submit a manufacturer's cost invoice, showing the purchase price for the pacemaker, as an attachment to the professional claim (*CMS-1500* claim form or electronic equivalent). The IHCP reimburses the provider at 120% of the cost invoice for this device. Procedure codes for pacemakers are available in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

Patient-Activated Event Recorder – Implantable Loop Recorder

The IHCP covers the patient-activated event recorder – implantable loop recorder (ILR) for use after a syncopal event. For specific coverage criteria, see the [Medical Policy Manual](#).

Claims should be billed with a primary diagnosis code that supports medical necessity. Neither the patient-activated event recorder – ILR nor the implantation procedure requires PA, but both are subject to retrospective review according to IHCP criteria. If a replacement recorder activator is needed, PA is required.

The device may not be implanted in the same member more often than every two years or 24 months.

The IHCP reimburses for the insertion and programming of the patient-activated event recorder –ILR. Removal of a patient-activated event recorder – ILR on the same day as the insertion of a cardiac pacemaker is considered part of the pacemaker insertion procedure and is not reimbursed separately. ECG analyses obtained during device insertion for signal quality and amplification purposes are considered part of the implant procedure and are not reimbursed separately.

The procedure code for the implantation of the patient-activated event recorder – ILR is CPT code 33282. The code for the removal of this device is 33284. These procedure codes have a 90-day global postoperative care designation for which care related to the surgical procedure is not separately reimbursable unless such care is nonroutine, such as treatment of complications.

The device may be implanted at any of three places of service: inpatient, outpatient, or physician's office. Table 8 illustrates billing instructions for each place of service:

- If the procedure is performed when the patient is an **inpatient** for a related problem, submit an institutional claim (*UB-04* claim form or electronic equivalent) using a medically necessary diagnosis code and revenue code 360.
- If the procedure is performed on an **outpatient** basis, submit an institutional claim (*UB-04* claim form or electronic equivalent) using revenue code 360 and CPT code 33282 for implantation. The facility should bill for the device itself on a professional claim (*CMS-1500* claim form or electronic equivalent) using HCPCS code E0616 with medically necessary primary diagnosis codes. Use CPT code 33284 with revenue code 360 to bill for removal of the device. Physician's charges for the surgery should be billed by the physician on a professional claim.
- If the procedure is performed in a **physician's office**, the physician should bill CPT code 33282 for implantation and E0616 for the device. Both codes are billed on a professional claim (*CMS-1500* claim form or electronic equivalent).

Table 8 – Implantable Loop Recorder Billing Based on Place-of-Service Code

	Inpatient	Outpatient	Physician's Office
Type of Claim	Institutional	Institutional (and professional, if billing for device)	Professional
Revenue Code	Revenue code 360	Revenue code 360	Revenue code not applicable
CPT Code for Procedure	CPT code not needed	CPT code 33282 for insertion CPT code 33284 for removal	CPT code 33282 for insertion CPT code 33284 for removal
HCPCS Code for Device	HCPCS code not needed	On institutional claim – HCPCS code not needed On professional claim – HCPCS code E0616	HCPCS code E0616
<p><i>Note: Institutional claim formats include the UB-04 paper claim form, the 837I electronic transaction, and the institutional claim type on the Provider Healthcare Portal.</i></p> <p><i>Professional claim formats include the CMS-1500 paper claim form, the 837P electronic transaction, and the professional claim type on the Provider Healthcare Portal.</i></p>			

For implantation and the device, providers must bill their usual and customary charges. Insertion of the device carries a 90-day global surgery designation with no assistant surgeon required. The recorder activator is furnished with the system and is not separately reimbursed.

The CPT code for analysis of information collected by the recorder is 93285 and should be billed only subsequent to the date of insertion. Initial analysis and monitoring is included in the fee for insertion; therefore, code 93285 may not be billed on the date of insertion. The programmer used to program the patient-activated event recorder – ILR to retrieve, display, and print stored data is furnished to the physician, but remains the property of the manufacturer.

Procedure codes for the implantable loop recorder system are available in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

Phrenic Nerve Stimulator (Breathing Pacemaker)

The phrenic nerve stimulator (breathing pacemaker) is an electrophrenic pacemaker for pacing the diaphragm. The device consists of an external radio frequency transmitter, an antenna, a subcutaneous radio receiver, and a bipolar platinum nerve electrode. Diaphragmatic pacing (intermittent electrical stimulation of the phrenic nerves) offers freedom from mechanical ventilation for patients who need long-term ventilation and have a functionally intact phrenic nerve and chest-wall stability. The IHCP covers the phrenic nerve stimulator subject to specific coverage criteria.

The decision of whether to perform the implantation on an inpatient or outpatient basis is made by the physician, as determined by the assessment of complicating factors and their severity at the time the procedure is planned.

Prior Authorization and Coverage Criteria

Prior authorization (PA) is required for the phrenic nerve stimulator and its implantation, whether the device is implanted on an inpatient or outpatient basis. Members who qualify for the phrenic nerve stimulator demonstrate life-threatening oxygen depletion when respiration is unassisted. Additional medical criteria listed in the [Medical Policy Manual](#) also apply.

One or more of the ICD diagnosis codes listed for the phrenic nerve stimulator in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com must be used when submitting requests for PA.

Note: The phrenic nerve stimulator should never be recommended for treatment of obstructive sleep apnea.

Documentation indicating medical necessity for the appropriate diagnosis must be submitted prior to surgical implantation of the stimulator wires.

The primary objective of implanting the phrenic nerve stimulator is to allow the member to return from a skilled nursing facility to a home environment and be more independent. Therefore, the following criteria are mandatory for prospective candidates requesting this device:

- Functional lungs and diaphragm muscle and both phrenic nerves
- Absence of infection in orofacial, neck, chest, or abdomen and any suspicion of systemic infection, including sepsis
- A clear and adequate upper airway (including nasopharynx, pharynx, and larynx)
- Family support that includes an unpaid, physical caregiver of adequate quality and the availability of nursing and medical care

The equipment is costly and requires preoperative testing of the components and thorough education of the member and his or her caregivers concerning its use.

Coding and Billing Instructions

When the phrenic nerve stimulator is implanted as an inpatient procedure, reimbursement for the implantation and the device is included in the inpatient DRG payment.

When the device is implanted as an outpatient procedure, revenue code 360 should be billed, along with the appropriate procedure code for implantation, on the institutional claim (*UB-04* claim form or electronic equivalent). For outpatient settings, the device itself should be billed by the facility as a DME item on a professional claim (*CMS-1500* claim form or electronic equivalent).

The procedure codes to use when submitting claims for phrenic nerve stimulator services and device are listed in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

Spinal Cord Stimulators

Spinal cord stimulation (SCS) is used to treat chronic pain intractable to other treatment. SCS is frequently used to treat failed back surgery, complex regional pain syndromes, peripheral neuropathies, angina, peripheral vascular disease, postherpetic neuralgia, occipital neuralgia, and chronic pelvic pain. This treatment is considered a last resort for individuals who have tried other treatment options that were unsuccessful for the management of intractable, chronic pain.

The IHCP covers SCS services when billed with the appropriate ICD diagnosis codes listed in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com. All other diagnoses of chronic, nonmalignant, neuropathic pain are considered for approval on a case-by-case basis by a pain management consultant, if all other PA criteria are met.

SCS treatment must be evaluated in a three- or seven-day trial stimulation period before permanent implantation. Providers must request PA for both the trial and permanent phases of this service. Specific PA criteria for the trial stimulation period and for permanent SCS implantation, including implantation for intractable angina, appear in the [Medical Policy Manual](#).

Following PA approval, providers must bill using the appropriate diagnosis and procedure codes for SCS services. Separate outpatient reimbursement for the SCS implantable device is allowed, subject to medical necessity and PA guidelines. ICD, CPT, and HCPCS codes for SCS services and equipment are available in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

Stents

The IHCP limits coverage of CPT code 37215 – *Insertion of stents and blood clot protection device in neck artery, open or accessed through the skin* to specific diagnoses. The applicable ICD-10 diagnosis codes are listed available in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

Outpatient reimbursement for the placement of drug-eluting stents and all associated facility charges is made using revenue codes 36X or 49X in combination with CPT codes 929XX.

Prior authorization is required for transcatheter placement of intravascular stents and is limited to members with stenosis at or above 70% for whom all other additional medical treatments have failed.

For intraocular stent coverage and billing information, see the [Vision Services](#) module.

Transcatheter Aortic Valve Replacement/Implantation

The IHCP provides coverage for transcatheter aortic valve replacement/transcatheter aortic valve implantation (TAVR/TAVI). The CPT codes for TAVR/TAVI are covered for all IHCP programs, subject to limitations established for certain benefit packages. The codes are listed in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com. No PA is required.

Vagus Nerve Stimulator

The vagus nerve stimulator (VNS) is indicated as an adjunctive therapy in reducing the frequency of seizures in members with partial onset seizures that are refractory to anti-epileptic medications, and for which surgery has failed or is not recommended.

Coverage Criteria and Prior Authorization Requirements

IHCP reimbursement for implantation, revision, programming and reprogramming, and removal of the vagus nerve stimulator is available for members of all ages with medically intractable partial onset seizures who are not otherwise surgical candidates. Providers are required to perform this procedure on an outpatient basis whenever medically possible. Implantation procedures and equipment require prior authorization with documentation of medical necessity.

In situations where a complicating factor is present, and the patient requires admission to the hospital for the procedure, medical history and records must support the need for the inpatient admission. When the procedure is performed in an inpatient setting, PA is required for the admission but not for the device, which is included in the DRG reimbursement for the inpatient procedure.

The physician must obtain PA for the implantation procedures, regardless of inpatient or outpatient setting. The following documentation must be maintained in the medical record and submitted with the PA request:

- Documentation that an evaluation has been made by a neurologist
- Documentation of the member's type of epilepsy

- Documentation that the member's seizures are medically intractable (member continues with an unacceptable number of seizures with adequate treatment with two or more anti-epileptic drugs [AEDs] for a period of at least 12 months)
- Documentation that the member is not an intracranial surgical candidate or that surgery has been unsuccessful (for example, the member is not a surgical candidate due to multiple epileptic foci)

Members with diagnoses of ominous prognosis or other limiting factors would not be considered appropriate candidates for the implantation of the vagus nerve stimulator (for example, members with an absent left vagus nerve, severe intellectual disability, cerebral palsy, stroke, progressive fatal neurologic disease, or progressive fatal medical disease).

The IHCP does not cover vagus nerve stimulators for resistant depression or treatment of chronic pain.

Billing and Reimbursement

Diagnosis and procedure codes to use when billing for the implantation, revision, programming and reprogramming, and removal of the vagus nerve stimulator are available in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

Billing for VNS Services

For hospital outpatient and ASC claims, CPT codes for the incision, implantation, revision, or removal of the vagus nerve stimulator must be billed in conjunction with the appropriate revenue code (360 or 490) on the institutional claim (*UB-04* claim form or electronic equivalent). The surgical procedure can involve two separate incisions. Reimbursement is based on 100% of the highest ASC group and 50% for the second-highest ASC group. No additional reimbursement is available for three or more procedures.

Surgeons and neurologists should bill professional services on the professional claim (*CMS-1500* claim form or electronic equivalent), using the appropriate CPT codes. Anesthesia practitioners use the same codes listed for surgeons, along with the appropriate modifiers.

Billing for Device Components

When the procedure is performed in an outpatient setting, additional reimbursement, separate from the ASC rate for the implantation, is allowed for the cost of the device. See the *Procedure Codes for Additional Reimbursement of the VNS Device and Components* table in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com. The device must be billed by the facility on a professional claim (*CMS-1500* claim form or electronic equivalent), and prior authorization must be obtained.

Note: In situations where a complicating factor is present and the patient requires admission to the hospital for the procedure, the procedure and device are reimbursed according to the appropriate DRG payment. The hospital stay must be billed as an institutional claim and must include a secondary diagnosis indicating a complicating factor that necessitated inpatient admission. DRG payments for inpatient procedures with complicating factors include reimbursement for the device. Hospitals cannot receive additional reimbursement, outside the DRG payment, for the cost of the device when the service is performed on an inpatient basis.

The IHCP created two HCPCS codes by appending the U1 modifier for providers to use when billing neurostimulator device components **for VNS diagnoses only**:

- L8680 U1 – *Implantable neurostimulator electrode, each, VNS only*
- L8686 U1 – *Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension, VNS only*

Claims submitted for HCPCS codes L8680 U1 and L8686 U1 with diagnosis codes not listed in the *ICD Diagnosis Codes for VNS Services* table will be denied with explanation of benefits (EOB) 4037 – *This procedure is not consistent with the diagnosis billed. Please verify and resubmit.*

HCPCS codes L8680 U1 and L8686 U1 are manually priced. Consistent with the IHCP's manual pricing methodology for DME, these codes are reimbursed at 75% of the manufacturer's suggested retail price (MSRP). Providers are required to submit **both** proof of the MSRP **and** an itemized cost invoice with the claim. (See the [Durable and Home Medical Equipment and Supplies](#) module for more information about MSRP documentation and cost invoices.)

Note that, when billing neurostimulator device components for **non-VNS use**, providers should continue to bill HCPCS codes L8680 and L8686 *without* the U1 modifier. These codes pay at a flat fee, as indicated on the [Fee Schedule](#).

Ventricular Assist Devices

The IHCP considers ventricular assist devices (VADs) medically necessary for the following conditions when certain medical criteria are met, as described in the [Medical Policy Manual](#):

- Postcardiotomy cardiogenic shock
- Bridge-to-transplant
- Destination therapy

A VAD is a covered service for postcardiotomy cardiogenic shock or bridge-to-transplant only if it has received approval from the FDA for the intended purpose, and only if it is used according to the FDA-approved labeling instructions for that intended purpose. A VAD is a covered service for destination therapy only if it has received approval from the FDA for destination therapy or as a bridge-to-transplant, or has been implanted as part of an FDA investigational device exemption trial for one of these two indications. Use of a non-FDA approved VAD is considered investigational and a noncovered service.

IHCP-covered services for implantation of VADs for postcardiotomy cardiogenic shock, bridge-to-transplant, and destination therapy are subject to postpayment review. Providers must maintain documentation in the member's medical record that indicates that **all criteria** have been met for implantation of a VAD. If all the criteria for implantation are not satisfied, reimbursement of funds may be recouped, including surgical fees, professional fees, and equipment costs.

VADs are noncovered for all conditions not previously listed. The artificial heart (for example, AbioCor or CardioWest) as a replacement heart for a diseased heart is not covered by the IHCP.

Appropriate ICD and CPT codes for billing implantation and removal of VADs are listed in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com. The tables include the following:

- The applicable ICD procedure codes for implantation, repair, and removal of a VAD. The ICD procedure code must be billed on the institutional claim (*UB-04* claim form or electronic equivalent) and is incorporated into the DRG payment.
- The applicable CPT codes for the physician component of the implantation or removal of a VAD. The CPT code should be billed on a professional claim (*CMS-1500* claim form or electronic equivalent).

VADs and their surgical implantation do not require PA. However, members who receive bridge-to-transplant or destination therapy, and who can continue therapy on an outpatient basis, require accessory equipment and supplies for use with the VAD. The accessory equipment, patient supplies, and replacement equipment require PA.

Stationary Power Base and Display Module

The power base is the electrical supply unit for the VAD. It provides tethered functioning of the VAD by powering the VAD and simultaneously recharging the batteries. The display module provides pump functioning information for the physician to evaluate patient status.

The hospital or DME provider purchases the power base as a capital expense and lends it to the member. The hospital or DME provider is reimbursed a rental payment while the equipment is used on an outpatient basis by the member.

The physician must submit a PA request for the VAD power base and display module using HCPCS code L9900 – *Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code* and modifier RR – *Rental use*. When billing, the description of the power unit and display module should be entered on a detail line, with HCPCS code L9900 placed in field 24D of the *CMS-1500* claim form or applicable field of the electronic claim. The total rental price may not exceed the purchase price. An invoice for each detail must accompany the claim when submitted.

Patient Supplies and Replacement Equipment

Patient supplies and replacement equipment include the system controller, rechargeable batteries, travel case, shower kit, and other miscellaneous supplies. The hospital or DME provider must supply the replacement parts. Prior authorization is required for VAD patient supplies and replacement equipment HCPCS codes listed in *Surgical Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

The description of the patient supplies or replacement equipment should be placed on a second detail line with the appropriate HCPCS code in field 24D of the *CMS-1500* claim form or applicable field of the electronic claim. An invoice for each detail must accompany the claim when submitted.