CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-8. Surgery

~~(a) **Use of medical and surgical modifiers.** The Physicians' Current Procedural Terminology (CPT) provides for 2-digit modifiers to further describe surgical services. These modifiers must be used on OHCA claims when applicable. Refer to the CPT for a complete description of modifiers.~~

~~(b) **Claims processing modifiers.**~~

~~(1) -26 Professional component;~~
~~(2) -50 Bilateral procedure;~~
~~(3) -51 Multiple procedures;~~
~~(4) -52 Reduced service;~~
~~(5) -54 Surgical care only;~~
~~(6) -55 Post-operative care only;~~
~~(7) -62 Two surgeons;~~
~~(8) -80 Assistant surgeon;~~
~~(9) -82 Assistant surgeon (when a qualified resident surgeon is not available);~~

~~(c) **Modifiers resulting in denial.** The use of the medical and surgical modifiers listed in this subsection results in denial of the procedure performed:~~

~~(1) -56 Pre-operative management only;~~
~~(2) -81 Minimum assistant surgeon;~~
~~(3) -90 Reference laboratory;~~
~~(4) -99 Multiple modifiers.~~

~~(d) **Modifiers subject to review.** The medical and surgical modifiers listed in this subsection are subject to review and may affect claims processing.~~

~~(1) -21 Prolonged evaluation and management (E&M) services;~~
~~(2) -22 Unusual procedural services;~~
~~(3) -23 Unusual anesthesia;~~
~~(4) -24 Unrelated E&M services by the same provider during the post-operative period;~~
~~(5) -25 Significant, separately identifiable E&M service by the same provider on the same day of a procedure or other service;~~
~~(6) -32 Mandated service;~~
~~(7) -47 Anesthesia by surgeon;~~
~~(8) -53 Disconnected procedure;~~
~~(9) -57 Decision for surgery;~~
~~(10) -58 Staged or related procedure;~~
~~(11) -59 Distinct procedural service;~~
~~(12) -63 Procedure performed on infants;~~
~~(13) -66 Surgical team;~~
~~(14) -76 Repeat procedure by same provider;~~
~~(15) -77 Repeat procedure by same provider;~~

~~(16) -78 Return to operating room;~~
~~(17) -79 Unrelated procedure; and~~
~~(18) -91 Repeat clinical diagnostic laboratory test.~~

~~(e) **General information regarding surgery.**~~

~~(1) The OHCA uses nationally recognized coding and editing guidelines for determination of reimbursement logic related to situations including, but not limited to, multiple, bilateral, assistant surgery, incidental, and mutually exclusive procedure codes. When a procedure is performed for which specific procedure codes exist, the specific procedure code must be used. A claim submitted with an "unlisted" procedure code is subject to medical review and requires the submission of all pertinent medical records for determination of payment.~~

~~(2) A separate payment is not made for pre and post operative care billed in conjunction with surgery. This does not apply to those specific surgical procedures where the fee is considered to be for the surgical procedure only or to the initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Payment for the preoperative visit on the date immediately prior to or on the date of the procedure, either in the hospital, or elsewhere to examine the patient, complete the hospital records and initiate the treatment program, is included in the listed value for surgery. All surgical procedures are considered to include typical, uncomplicated, follow-up care unless otherwise indicated.~~

~~(3) A cochlear implant is covered for members under 18 years of age based on medical necessity; prior authorization is required.~~

~~(4) Postoperative care following cataract surgery may be performed by an optometrist or an ophthalmologist. When a physician transfers the care of a SoonerCare member to another provider for postoperative care, the appropriate CPT modifier (54 or 55) must be added to the surgical procedure code.~~

~~(5) Reduction mammoplasty is covered only when the procedure has been determined medically necessary; prior authorization is required.~~

~~(6) Intradermal introduction of pigments or tattooing is compensable when related to breast cancer reconstruction after surgery for breast cancer, prior authorization is required.~~

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modifiers must be used on OHCA claims when applicable.
(c) Reduction mammoplasty is covered only when the procedure has been determined medically necessary; prior authorization is required.
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