Surgery (Professional)

Payment Policy

**Policy**

Blue Cross Blue Shield of Massachusetts (Blue Cross®) reimburses contracted health care providers for covered, medically necessary surgical procedures.

**General benefit information**

Covered services and payment are based on the member’s benefit plan and provider Agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our eTools page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayments, deductibles, and co-insurance. Members’ costs depend on member benefits.

Certain services require prior authorization or referral.

**Payment information**

Blue Cross reimburses health care providers based on your contracted rate and member benefit:

Claims are subject to payment edits, which Blue Cross updates regularly.

**Blue Cross reimburses:**

- Global surgical package/days. The global surgical package includes all the necessary services normally provided by a surgeon before, during, and after a procedure. The payment for a surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.
  - Consistent with the Centers for Medicare & Medicaid Services (CMS), Blue Cross uses the National Physician Fee Schedule (NPFS) file to determine the global day periods (0, 10, and 90) assigned to surgical services and adheres to the CMS definition of the global surgical package. The following services are included in the surgical service payment and are not separately reimbursed:
    - Pre-operative visits—one day prior for major surgeries and on the same day a major or minor surgery is performed.
    - Intra-operative services.
    - Post-operative visits.
    - Post-surgical pain management by the surgeon.
    - Supplies, except for those identified as exclusions.
    - Miscellaneous services—items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.
    - Complications following surgery—all additional medical or surgical services required of the surgeon during the post-operative period which do not require an additional trip to the operating room.

- Services reimbursed in addition to the global rate with the appropriate modifier
  - The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Please note that this policy applies only to major surgical procedures. The initial evaluation is always included in the allowance for a minor surgical procedure.
  - Services of other providers except where the surgeon and the other providers agree on the transfer of care.
  - Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery.
  - Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery.
  - Diagnostic tests and procedures.
  - Distinct surgical procedures during the post-operative period which are not re-operations or treatment for complications.
    - A new post-operative period begins with the subsequent procedure. This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure.
o Treatment for post-operative complications which requires a return trip to the operating room.
o Immunosuppressive therapy for organ transplants.
o If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.

• Multiple procedures
  o In the case of multiple payable procedures, the service with the higher provider resource consumption is reimbursed in full. The service with the lower provider resource consumption is paid at 50% of that procedure’s allowance. The fee reduction cannot be balance-billed to the patient.

• Bilateral procedures
  o Blue Cross reimburses bilateral services performed on both sides of the body during the same operative session or on the same day at 150% of the fee schedule allowance for a single service.

• Add-on codes
  o Add-on codes are reimbursed at 100% of the allowable rate and are not subject to the multiple procedure reduction.
  o Add-on codes are only those codes designated by CPT and identified by a specific descriptor that includes the phrase “each additional” or “list separately in addition to the primary procedure.”
  o Add-on codes are reimbursable only when billed with their accompanying primary procedure as defined in CPT.

• Co-surgery
  o Co-surgery is reimbursed at 62.5% of the fee schedule allowance for the procedure.

• Split surgical services
  o Reimbursement is based on the applicable percent as defined by CMS NPFS file not to exceed what would have been paid if a single physician had provided all services, when billed with appropriate modifier.

• Team surgery
  o Reimbursement is based on individual review.

• Assistant surgery services for those procedures defined by the CMS NPFS relative value file with an assistant surgery status indicator of “2.” The member cannot be held liable for non-qualifying procedure codes for only the participating provider, unless we communicated in writing.
  o Reimbursement for applicable procedures is at 16% of the surgical contracted rate when reported with the appropriate modifier.
  o Reimbursement for physician assistants (PA) and nurse practitioners (NP) designated as specialty care (PA-SC, NP-SC) or certified nurse midwives (CNMs) when assist at surgery is at 85% of the assistant surgeon’s allowable when reported with the appropriate modifier.
  o Multiple procedures billed as assist at surgery, at 50% of the applicable assistant rate for the second and any subsequent procedures. This is applicable to all surgical assist provider types.

• Second opinions
  o When requested by a member and/or his or her primary care provider or attending provider on a clinical decision related to a covered service such as diagnosis, treatment, consultation and surgery.

• Unlisted codes
  o Unlisted surgical CPT codes are reimbursed after individual consideration and review of the operative notes.

• Reduced services when reported with the appropriate modifier at 50% of the fee schedule allowable.

• Unplanned return trip to the operating room at 80% of the fee schedule allowable.

• FDA-approved skin substitutes or replacements and their application, for use by one patient only, when medically necessary. Please refer to our medical policy for specific information on when these substitutes and replacements are considered medically necessary.
Blue Cross does not reimburse:

- Nasal endoscopy for post-operative debridement following functional endoscopic sinus surgery, nasal or sinus cavities, unilateral or bilateral.
- “Minimally invasive” surgery at a rate different from the conventional surgery.
- Nasal or sinus endoscopy (surgical with biopsy, polypectomy or debridement) following a 10/90 day global surgery code.
- Robotic surgical systems (no additional reimbursement beyond the underlying surgery fee).
- Surgical trays.
- Nurse practitioner (NP) and physician assistant (PA) services for assistant surgery when the NP or PA provider is designated as primary care (NP-PC or PA-PC).
- Individuals who are in training to assist at surgery, unless we communicated otherwise in writing (examples: students, trainees, interns, residents, and fellows).
- Any provider type other than MD, NP-SC, PA-SC or CNM for assistant surgery services. This includes registered nurse first assists (RNFA), certified first assists (CFA), and certified surgical first assists (CSFA).
- Dental services under the medical benefit, with the exception of impacted wisdom teeth (third molars)
  - Certain services related to accidents
  - Cleft lip or cleft palate for members under age 18
  - Even if a dental condition is caused by a reimbursable medical condition or the result of treatment for a reimbursable medical condition, they are still not reimbursed under the medical benefit. Please refer to the Dental Care Payment Policy for additional information. This is in accordance with the subscriber certificate.

General reimbursement information

Moderate sedation reimbursement information:

- Attending physician
  - Use these codes when moderate sedation is provided by the same physician performing the procedure.

- Second physician
  - Moderate sedation provided in a facility setting when rendered by a separate provider from the provider performing the procedure, will be separately reimbursed when reported with modifier 59 or XP.
  - Moderate sedation provided in a non-facility place of service setting will not be separately reimbursed.

Billing information

Specific billing guidelines

- Bill the appropriate procedure on one line with only one unit of service per day.
- More than one physician may furnish services included in the global surgical package. This is reported using modifiers 54 and 55.
- Payment for the post-operative, post-discharge care is split among two or more physicians when the physicians agree on the transfer of care and it is documented in the medical record. This is not appropriate for surgical procedures with a 0 day global period. Where physicians agree to the transfer of care during the global period, report services with the appropriate modifier:
  - Modifier “-54” (surgical care only)
  - Modifier “-55” (post-operative management only)
  - Do not report modifiers 54 or 55 for assistant surgeon services
- Surgery and anesthesia services rendered by an oral and maxillofacial surgeon should be billed using the applicable HCPCS Level II D codes.
- Report bilateral services on one line of the 1500 claim form with modifier 50 and one unit of service.

The list of codes below is included for informational purposes only. This may not be a complete list of all the codes related to this service. Whether or not a code is listed here does not guarantee coverage or reimbursement.

<table>
<thead>
<tr>
<th>Code</th>
<th>Service description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>52</td>
<td>Reduced services.</td>
<td>Reimbursed at 50% of fee schedule allowable.</td>
</tr>
<tr>
<td>54</td>
<td>Surgical care only.</td>
<td>Reimbursement is based on the CMS percent discount to the full allowance posted in the NPFS for the applicable procedure.</td>
</tr>
<tr>
<td>Code</td>
<td>Service description</td>
<td>Comments</td>
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<tr>
<td>55</td>
<td>Post-operative management only.</td>
<td>• Reimbursement is based on the CMS percent discount to the full allowance posted in the NPFS for the applicable procedure.</td>
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<tr>
<td></td>
<td></td>
<td>• Reported by the provider performing the post-operative care.</td>
</tr>
<tr>
<td>56</td>
<td>Pre-operative management only.</td>
<td>Reimbursement is based on the percent discount to the full allowance posted in the NPFS for the applicable procedure.</td>
</tr>
<tr>
<td>57</td>
<td>Decision for surgery.</td>
<td>• Report with evaluation and management (E/M) code.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Valid for major surgeries only (90 day global periods).</td>
</tr>
<tr>
<td>62</td>
<td>Two surgeons.</td>
<td>Reimbursed at 62.5% of fee schedule allowable per surgeon.</td>
</tr>
<tr>
<td>66</td>
<td>Surgical team.</td>
<td>Reimbursement based on review.</td>
</tr>
<tr>
<td>78</td>
<td>Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the post-operative period.</td>
<td>Reimbursed at 80%.</td>
</tr>
<tr>
<td>80</td>
<td>Assistant surgeon.</td>
<td>Report in first modifier field.</td>
</tr>
<tr>
<td>81</td>
<td>Minimum assistant surgeon.</td>
<td></td>
</tr>
<tr>
<td>82</td>
<td>Assistant surgeon (when qualified resident surgeon not available).</td>
<td></td>
</tr>
<tr>
<td>AS</td>
<td>Physician assistant (PA-SC), nurse practitioner (NP-SC), or clinical nurse specialist services for assistant at surgery.</td>
<td>• Must be performed by a PA-SC, NP-SC, or CNM only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Report in first modifier field.</td>
</tr>
<tr>
<td></td>
<td><strong>CPT and HCPCS codes</strong></td>
<td></td>
</tr>
<tr>
<td>20552</td>
<td>Injection; single or multiple trigger points, 1 or 2 muscles.</td>
<td>• Bill with one unit for one or two muscle groups, regardless of the number of trigger points.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If billed on the same day as CPT 20553, this code will not be reimbursed.</td>
</tr>
<tr>
<td>20553</td>
<td>Injection; single or multiple trigger points, 3 or more muscles.</td>
<td>Bill with one unit for three or more muscle groups, regardless of the number of trigger points.</td>
</tr>
<tr>
<td>20985</td>
<td>Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (list separately in addition to code for primary procedure).</td>
<td>Not reimbursed.</td>
</tr>
<tr>
<td>31237</td>
<td>Nasal or sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure).</td>
<td>Not reimbursed when reported within the 10/90 day global period of another surgical service.</td>
</tr>
<tr>
<td>36415</td>
<td>Collection of venous blood by venipuncture.</td>
<td>Not reimbursed with blood lab tests or E/M services.</td>
</tr>
<tr>
<td>36416</td>
<td>Collection of capillary blood specimen.</td>
<td>Not reimbursed.</td>
</tr>
<tr>
<td>99151</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age.</td>
<td>• All codes continue to be subject to standard claim edits. For example, 99152 will deny when billed with gastroenterology procedure codes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use HCPCS code G0500 to bill moderate sedation with gastroenterology procedure codes.</td>
</tr>
<tr>
<td>99152</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age.</td>
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<tr>
<td>Code</td>
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|        | trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older.                                                                                                           | • Must be billed with CPT 99151, 99152 or G0500  
• Use HCPCS code G0500 to bill moderate sedation with gastroenterology procedure codes.                                                                                                                   |    |
| 99153  | Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service). | Moderate sedation provided in a non-facility place of service setting will not be separately reimbursed.                                                                                              |    |
| 99155  | Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient younger than 5 years of age. |                                                                                                                                                                                                         |    |
| 99156  | Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older. | • Must be billed with CPT 99155 or 99156  
• Moderate sedation provided in a non-facility place of service setting will not be separately reimbursed.                                                                                           |    |
| 99157  | Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (list separately in addition to code for primary service). |                                                                                                                                                                                                         |    |
| A4550  | Surgical trays.                                                                                                                                                                                                                                                                                                                                       | Not reimbursed.                                                                                                                                                                                     |    |
| G0500  | Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service.                                                                                                                                                                                                       | • Report only with Gastrointestinal endoscopic codes  
• Additional time may be reported with CPT 99153.                                                                                                                                                         |    |
| Q4101- Q4202 | Skin substitutes/wound matrix.                                                                                                                                                                                                                                                                                                                      | See medical policy for coverage details.                                                                                                                                                               |    |
| S2900  | Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure).                                                                                                                                                                                                                                  | Not reimbursed.                                                                                                                                                                                     |    |

When submitting claims for reimbursement, report all services with:
• Up-to-date industry-standard procedure and diagnosis codes, and
• Modifiers that affect payment in the first modifier field, followed by informational modifiers.
# Billing and coding scenarios

## Significant separately identifiable E/M service (modifier 25):

### Correct use:
- An established patient has a complex anterior nosebleed. The provider packs the nose in the office, stopping the bleeding.
- At the same visit, the provider then evaluates the patient for moderate hypertension that was not well-controlled and adjusts the antihypertensive medications.
- **Bill 99213-25** (or appropriate E/M level code) and **CPT 30903**.

The 25 modifier may be reported with the appropriate level of E/M code in addition to CPT 30903. The hypertension E/M was medically necessary, significant, and a separately identifiable service performed on the same day as control of the nosebleed. The hypertension was exacerbating the nosebleed and was actually related to the nosebleed, but management of the hypertension was a separate service from actually packing the nose.

### Incorrect use:
- A patient is seen in the office and has a .5 cm malignant lesion of the arm. After examination, it is removed by surgical curettement.
- No other conditions are treated.
- **Report CPT 17260 only.**

The use of the 25 modifier is inappropriate. The office visit is considered part of the surgery service and, therefore, not separately reimbursable.

## Split care (modifiers 54 and 55):

- A surgeon performs cataract surgery on a patient and transfers post-operative care to an optometrist the next day.
- The surgeon **reports CPT 66984-54**; the optometrist **reports 66984-55**. The date of service is the date of surgery.

## E/M service resulting in the initial decision to perform surgery (modifier 57):

### Correct use:
- An established patient was seen in the office after a trip and fall for ankle pain and swelling. The patient was found to have a posterior malleolus fracture.
- Surgical repair and pinning was recommended and performed the following day by the same provider.
- **Bill 99213-57 or appropriate level E/M for visit and 27769 for fracture repair.**

Modifier 57 is used to show that the E/M visit resulted in the decision for surgery. The surgery has a 90 day global period therefore the modifier 57 is appropriate for use.

### Incorrect use:
- An established patient is seen in the office for five benign itchy bleeding skin lesions that are catching on clothing.
- The provider examines the area and decides to perform cryosurgery to destroy the lesions.
- **Report CPT 17110.**

Billing E/M and modifier 57 is not appropriate as CPT 17110 has a 10 day global period; modifier 57 is appropriate for 90 day global procedures only.
Related policies
- Bilateral Services
- CPT and HCPCS modifiers
- Dental Care
- Evaluation and Management
- General Coding and Billing
- Medical policies
- Non-Reimbursable Services
- Orthopedic Services

Policy update history

12/01/2009  Documentation of existing policy.
12/18/2013  Template update; addition of information on guidelines for global surgical package.
11/12/2014  Template update, annual review.
05/28/2015  Minor edits for clarity.
11/04/2015  Template update; annual review; edits for clarify; inclusion of information on bilateral procedures, oral surgery, nasal surgery, and trigger point injections.
03/31/2016  Annual review; template update; inclusion of detailed documentation on existing policy on add-on codes, global surgical package/days, split surgery, team surgery, non-reimbursed services, and specific billing guidelines.
06/01/2017  Annual review; template update; inclusion of specific billing guidelines; inclusion of reimbursement policy on assistant surgery services; updates to reimbursement guidelines for moderate sedation.
09/30/2017  Clarification of assistant surgeon reimbursement policy.
11/01/2017  Clarification that standard claim edits apply to moderate sedation reimbursement.
06/30/2018  Clarification of billing guidelines; inclusion of reimbursement, billing scenarios, minimally invasive surgery, skin replacement information, removal of outdated moderate sedation coding information.
12/31/2018  Annual coding review; expansion of code set for skin products to include new codes.
03/31/2019  Annual review, template update, updated comments section for add on codes, inclusion of detailed documentation on existing policy on second opinion and unlisted codes, added policies to related policy; revised comments section for moderate sedation codes.

This document is for informational purposes only and is not an authorization, an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts’ payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy development takes into consideration a variety of factors, including: the terms of the participating provider’s contract(s); scope of benefits included in a given member’s benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.