

Ambulatory Surgery – Professional Payment Policy

(Same-day surgical procedures)

Policy

The Plan reimburses medically necessary professional surgical services provided in either an Outpatient Surgical Service (Non-Ambulatory Surgical Center) or an Ambulatory Surgical Center-designated facility.

Definitions

Outpatient Surgical Services typically do not require an overnight stay. These services may include pain management and certain diagnostic services that can be performed in an outpatient setting. These services are billed utilizing CPT surgical codes. Providers are reimbursed subject to all Plan outpatient billing and payment, bundling and global package rules. The Plan refers to a surgical day services (SDS) procedures listing to identify surgical services that are covered. Additionally, outpatient surgical services are defined as major or minor.

Ambulatory Surgical Centers (ASCs) also specialize in providing surgery, pain management and certain diagnostic services in an outpatient setting. These services are also billed utilizing CPT surgical codes.

Reimbursement

The Plan does reimburse for outpatient/ambulatory surgery/significant procedures as per contractual arrangement.

Bilateral surgeries are typically reimbursed at 150% of the contracted allowable rate for the procedure when billed on one line with the 50 modifier appended to the procedure code; 100% to be paid for first side, 50% to be paid for second side.

Bundled services:

- The Plan only reimburses the more “intensive” CPT code when a procedure is considered to be part of a more comprehensive procedure or when a single more comprehensive CPT code more accurately describes a group of procedures.

Multiple surgical services:

- The Plan closely aligns with CMS guidelines in determining which procedure codes are subject to multiple procedure reduction. Reference the CMS website for information on specific procedure codes.
- When multiple surgical services are performed at the same session, the procedure with the highest intensity is reimbursed at full payment; when allowed, others are reimbursed at 50% of the contracted fee or pursuant to contractual arrangement.
- No additional payment is made beyond five services.

Payments are subject to post-payment audits and retraction of overpayments.

The Plan does not reimburse:

- Needle electromyography (95867-95872) or short-latency somatosensory/central motor evoked potential studies (95925-95929) billed by the primary surgeon.
- Ambulatory surgical day procedures if they are deemed:
 - Not medically necessary.
 - Those services that require prior authorization by the Plan when authorization was not obtained. The member may not be billed for non-authorized services when performed by contracted providers at contracted facilities.
 - Services provided by residents.

Referral/notification/prior authorization requirements

PCP referrals are required for all specialty visits for most products. For a description of products and services requiring a PCP referral, please refer to the PCP referral and prior authorization grid located in the *Managing Patient Care* section of the *Provider Manual* under *PCP Referral and Plan Prior Authorization Process*.

The ordering physician is required to obtain prior authorization for:

- Unlisted CPT codes
- The applicable codes found on the *List of Procedures Requiring Prior Authorization* located in the *Managing Patient Care* section of the *Provider Manual* under *PCP Referral and Plan Prior Authorization Process*.

Fallon Health Weinberg and Navicare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

Two providers – same surgery:

- If one physician performs the surgery and another renders the post-op care they may each bill with appropriate modifiers affixed to the claim.

Bundled services:

- The Plan only reimburses the more “intensive” CPT code when a procedure is considered to be part of a more comprehensive procedure or when a single more comprehensive CPT code more accurately describes a group of procedures.

Multiple surgical services:

- When multiple surgical services are performed at the same session, the procedure with the highest intensity is reimbursed at 100% of the contracted allowable rate and all subsequent reimbursable procedures are paid at 50% of the allowable rate up to 5 procedures, or pursuant to contractual arrangement.

Add-on codes:

- Add-on codes are reimbursed at 100% of the contracted allowable rate and are NOT subject to the multiple surgical services rule for reduction in payment.
- Add-on codes cannot be billed alone.

Assistant at surgery – Physician:

- Reimbursement is made at 16% of the surgeon's contracted allowable rate.

Co-surgery:

- If Medicare allows payment, reimbursement is made at 63% of the contracted allowable rate for each provider.
- Separate operative notes may be requested from each provider documenting their distinctly separate portions of the procedure.

Attempted surgical procedure:

- The Plan will reimburse at a reduced rate of the contractual fee schedule based on the level of services provided when modifier 53 is affixed to indicate discontinued outpatient procedures; the appropriate modifier must be appended and supporting documentation may be requested.

Reduced surgical procedures:

- When modifier 52 is affixed to indicate reduced services, the Plan will reimburse at 50% of the contracted allowable rate.

Modifiers:

The following is a list of modifiers often used in surgical billing for both ASC and Non-ASC:

- 24 - Services unrelated to surgical service during post-operative period. Use modifier 24 for post-op services when billing for services that are unrelated to the surgical procedure; notes are required.
- 25 - Significant separately identifiable service on the same day as another E&M.
- 50 - Bilateral procedure.
- 51 - Multiple procedures (not for Medicare).
- 52 - Reduced services.
- 53 - Discontinued service (Professional side only; Facility uses 73/74).
- 54 - Surgical Service only.
- 55 - Post-op surgical service only.
- 56 - Pre-Op surgical service only.
- 57 - E&M service provided on same day as major surgery.
- 58 - Staged or related procedure or service by same physician on same day.
- 59 - Distinct procedural service.
- 62 - Two Surgeons.
- 66 - Team Surgery.
- 76 - Repeat procedure or service by same physician.
- 77 - Repeat procedure by another physician.
- 78 - Unplanned return to the operating/procedure room for a related procedure during the postoperative period.
- 79 - Unrelated procedure or service by the same physician on the same day.
- 80 - Assistant at Surgery.
- 82 - Qualified Resident.
- AS - Services provided by PA, NP, or CNS.

Place of service

This policy applies to professional services that are submitted with a place of service 19 or 22 indicating an Outpatient Hospital, or place of service 24 indicating an Ambulatory Surgical Center (ASC).

Policy history

Origination date:	11/01/2008
Previous revision date(s):	09/01/2009 - Clarified language in the Reimbursement, Referral/notification/preauthorization requirements and Billing/coding sections. 11/1/2010 - Updated discussion of operative note review and post-payment audits in the Reimbursement section. 7/1/2011 - Updated discussion about multiple surgical services. 05/01/2015 - Noted prepayment review process and moved to new template. 01/01/2016 – Moved to new Plan template. 05/01/2016 - Added POS 19.
Connection date & details:	March 2017 – Annual review. April 2018 – Annual review, no updates. July 2018 – Removed language surrounding \$1000 plus claims being subject to pre-payment review. October 2019 – Clarified billing section language.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.