Manual: Reimbursement Policy

Policy Title: **Procedure Codes Assigned to Surgical Benefit Categories**

Section: Surgery

Subsection: None

Date of Origin: 1/1/2000 **Policy Number:** RPM023

Last Updated: 5/4/2018 **Last Reviewed:** 8/10/2018

Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

Reimbursement Guidelines

Procedure codes are assigned to a surgical benefit category when the procedure code is considered a surgical procedure by either the American Medical Association (AMA) or by Medicare (CMS).

- CPT codes listed in the Surgical section of the CPT book (10000 – 69999), are considered a surgical procedure code by the AMA.
- CPT codes in the Medical section of the CPT book (90000 – 99999) with a global days indicator of "0," "10," "90," "YYY," and "ZZZ" are considered a surgical procedure code by Medicare.
- HCPCS procedure codes with a global days indicator of "0," "10," "90," "YYY," and "ZZZ" are considered a surgical procedure code by Medicare.
- Specific Maternity procedures (cesarean delivery, Ligation or transection of fallopian tube(s), hysterectomy after cesarean delivery, etc.) are also considered Maternity surgical codes.

A procedure does not have to be performed in an operating room or under anesthesia to be considered a surgical procedure. A procedure does not have to be performed under anesthesia or use a skin incision or sutures to be considered a surgical procedure. Depending upon the nature and extent of the service, a surgical procedure may be performed in a wide variety of settings, including:

- Physician's office
- Patient room or bedside
- Emergency department
- Cath lab

- Interventional radiology procedure room
- Endoscopy room
- Operating room

Specific Examples

The following types of procedures may not initially appear to be surgical procedures, but are assigned to a surgical benefit category. This list is not intended to be comprehensive to address every type of question which may arise.

Closed Treatment of Fractures or Dislocated Joints
Some fractures and joint dislocations can be treated with x-ray assessment, ensuring proper alignment of the bones and/or joint, and stabilization and immobilization with a cast or splint. Procedure codes for closed treatment of a fractured bone, with or without manipulation, and treatment of a closed joint dislocation, with or without anesthesia, are listed in the surgical section of the CPT book.

Application of Casts and Strapping
Procedure codes for the application of casts and/or strapping are listed in the surgical section of the CPT book.
(Note: Specific coding and bundling rules are listed in the CPT book and/or the CPT Assistant as to when these procedures may and may not be separately reported and/or reimbursed.)

Endoscopy procedures
An endoscopy is the examination and treatment of the inside of the body by using a lighted, flexible instrument called an endoscope. In general, an endoscope is introduced into the body through a natural opening such as the mouth or anus. Although endoscopy can include examination of other organs, the most common endoscopic procedures evaluate the nose, sinuses, esophagus, stomach, and portions of the intestine. Tools for cutting, grasping, cautery, balloon dilation, or other tools may be attached or passed through the endoscope instrument.

Endoscopy procedures are considered surgical procedures. Endoscopy procedure codes are listed in the surgical section of the CPT book or are HCPCS codes designated as a surgical procedure by Medicare.

Cardiac catheterization procedures
Cardiac catheterization procedures access the heart for examination and/or treatment by passing a small tube through the skin into a blood vessel (usually in the groin or neck) and through the blood vessels to the heart. These procedures usually take place in a special radiology procedure room (e.g. cath lab) using light sedation.

Cardiac catheterization procedure codes are in the Medicine section of the CPT book, but are designated as surgical procedures by Medicare.

Needle biopsies and other percutaneous needle procedures
A number of procedures access organs, muscles, tissues, or joints with a needle inserted through the skin. This includes needle biopsies, trigger point injections, aspiration of fluid from a joint, or injection of substances into the joint, etc. These are considered surgical procedures by the AMA and/or Medicare, and the procedure codes are generally listed in the surgical section of the CPT book.

Removal of warts, skin tags, etc.
Warts, skin tags, actinic keratosis lesions, and other benign lesions can be removed by a variety of means, such as laser, electrosurgery, cryosurgery (application of cold, liquid nitrogen, "freezing"), application of other chemicals, etc. These procedures are considered surgical procedures and the procedure codes are listed in the surgical section of the CPT book

Background Information

Every procedure code (CPT and HCPCS) is assigned to a benefit category for claims adjudication. This policy is intended to help explain why procedures which may not require an operating room or involve an incision or sutures are considered a surgical procedure and assigned to a surgical benefit category.

Codes and Definitions

CMS Global days (period) indicators currently in use are:

000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

MMM = Maternity codes; usual global period does not apply.

XXX = Global concept does not apply.

YYY = Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ = Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post service time.)

Coding Guidelines

The American Medical Association (AMA) is the source of CPT codes.

The Centers for Medicare and Medicaid Services (CMS, Medicare) is the source of HCPCS Level II codes. Medicare also assigns a global surgical period (global days) indicator to all procedure codes on the Medicare Physician Fee Schedule Database (MPFSDB).

- Surgical codes have a global days indicator of "0," "10," "90," "YYY," "ZZZ," and "MMM."
- Non-surgical codes (medical procedures, lab tests, radiology procedures, evaluation and management services, supply procedures, DME items, etc.) have a global days indicator of "XXX" (global surgery concept does not apply).

Cross References

A. "Global Surgery Package for Professional Claims." Moda Health Reimbursement Policy Manual, RPM011.

B. "Modifier 51 - Multiple Procedure Fee Reductions." Moda Health Reimbursement Policy Manual, RPM022.

References & Resources

1. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, Addendum - MPFSDB Record Layouts.

2. "Definition of Endoscopy." *MedicineNet.com*. (Owned and operated by WebMD). Accessed April 9, 2013; http://www.medterms.com/script/main/art.asp?articlekey=12538.

IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry

standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.