

	Reimbursement Policy Manual		Policy #:	RPM023
Policy Title:	Procedure Codes Assigned to Surgical Benefit Categories			
Section:	Surgery	Subsection:	None	
Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:				
Companies:				
<input checked="" type="checkbox"/> All Companies: Moda Partners, Inc. and its subsidiaries & affiliates <input type="checkbox"/> Moda Health Plan <input type="checkbox"/> Moda Assurance Company <input type="checkbox"/> Summit Health Plan <input type="checkbox"/> Eastern Oregon Coordinated Care Organization (EOCCO) <input type="checkbox"/> OHSU Health IDS				
Types of Business:				
<input checked="" type="checkbox"/> All Types <input type="checkbox"/> Commercial Group <input type="checkbox"/> Commercial Individual <input type="checkbox"/> Commercial Marketplace/Exchange <input type="checkbox"/> Commercial Self-funded <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Short Term <input type="checkbox"/> Other: _____				
States:				
<input checked="" type="checkbox"/> All States <input type="checkbox"/> Alaska <input type="checkbox"/> Idaho <input type="checkbox"/> Oregon <input type="checkbox"/> Texas <input type="checkbox"/> Washington				
Claim forms:				
<input checked="" type="checkbox"/> CMS1500 <input checked="" type="checkbox"/> CMS1450/UB (or the electronic equivalent or successor forms)				
Date:				
<input checked="" type="checkbox"/> All dates <input type="checkbox"/> Specific date(s): _____ <input type="checkbox"/> Date of Service; For Facilities: <input type="checkbox"/> n/a <input type="checkbox"/> Facility admission <input type="checkbox"/> Facility discharge <input type="checkbox"/> Date of processing				
Provider Contract Status:				
<input checked="" type="checkbox"/> Contracted directly, any/all networks <input checked="" type="checkbox"/> Contracted with a secondary network <input checked="" type="checkbox"/> Out of Network				
Originally Effective:	1/1/2000	Initially Published:	5/8/2013	
Last Updated:	10/12/2022	Last Reviewed:	10/12/2022	
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No				
Last Update Effective Date for Texas:		10/12/2022		

Reimbursement Guidelines

A. General

Procedure codes are assigned to a surgical benefit category based on the nature of the procedure and when Medicare (CMS) considers the code to be a surgical procedure based on the various indicators on the physician fee schedule.

B. Types of Surgical Benefit Categories

Surgical benefit categories include both general surgical procedures and certain specific surgery benefit categories, including but not limited to:

- Endoscopic surgery
- Infertility surgery
- Family Planning surgery
- Maternity surgery
- Medicare Routine Foot Care
- Transplant surgery

C. Nature of the Procedure

Surgical procedures do not always require general anesthesia, an operating room, a skin incision, or sutures to be considered a surgical procedure. Surgical procedures include but are not limited to the following:

- Incision
- Excision
- Amputation
- Introduction (of needles, catheters, or instruments, etc.)
- Endoscopy
- Repair
- Destruction (e.g., warts, lesions, abnormal tissue, etc.)
- Sutures
- Manipulation
 - Treatment of fractures
 - Treatment of dislocations
- Treatment of burns

D. Medicare (CMS) Indicators of Surgical Procedures

1. Global Surgery Days Indicator.
 - a. All procedure codes with a global days indicator of “10” and “90” on the Medicare (CMS) physician fee schedule are considered a surgical procedure code.
 - b. Procedure codes with a global days indicator of “0” days:
 - i. Most are considered a surgical procedure code.
 - ii. Some are not considered a surgical procedure code, depending upon the nature of the service described.
 - c. Global days indicator of “MMM” are considered maternity services. Specific Maternity procedures (cesarean delivery, Ligation or transection of fallopian tube(s), hysterectomy after cesarean delivery, etc.) are also considered Maternity surgical codes.
 - d. Procedure codes with a global days indicator of “XXX,” “YYY,” and “ZZZ” may be considered a surgical procedure code, depending upon the nature of the service described.

Contributing factors to help clarify the nature of the service include:

 - i. Key words in the procedure code description.
 - ii. Methods used to perform the procedure.
 - iii. Other indicators on the physician fee schedule.
2. When a determination needs to be made whether a new procedure code is or is not a surgical procedure before the CMS indicator information is available (global surgery days and others), the procedure code description wording itself is used to make the determination.

E. Locations and Settings

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

F. 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.

1. 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 and are assigned global surgery package days on the CMS Physician Fee Schedule.

2. 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 and are assigned global surgery package days of 000 on the CMS Physician Fee Schedule.

(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.)

3. 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 HCPCS codes and are assigned global surgery package days on the CMS Physician Fee Schedule .

4. Cardiac catheterization and cardiac electrophysiology procedures

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

5. 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 (but not always) listed in the surgical section of the CPT book.

6. 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, electro-surgery, cryosurgery (application of cold, liquid nitrogen, “freezing”), application of other chemicals, etc. These procedures are considered surgical procedures, are listed in the surgical section of the CPT book, and are assigned global surgery package days on the CMS Physician Fee Schedule.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see “NCCI”)
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
RPM	=	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
UB	=	Uniform Bill

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

Global Days Indicator	Indicator Definition
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 & Sources - (Key quotes, not all-inclusive)

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

- “Global Surgery Package for Professional Claims.” Moda Health Reimbursement Policy Manual, RPM011.
- “Modifier 51 - Multiple Procedure Fee Reductions.” Moda Health Reimbursement Policy Manual, RPM022.
- “Modifiers 58, 78, and 79 – Staged, Related, and Unrelated Procedures.” Moda Health Reimbursement Policy Manual, RPM010.

- D. "Modifiers 54, 55, and 56 – Split Surgical Care." Moda Health Reimbursement Policy Manual, RPM030.

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>.

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.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to 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 member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
10/12/2022	Formatting & clarification/Update: Change to new header; includes Idaho. Section F: Wording CMS global surgery package days values added. Cross References: 2 entries added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
5/8/2013	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
Prior to 1/1/2000	Original Effective Date (with or without formal documentation). Policy based on the nature of the procedure and various CMS Physician Fee Schedule status indicators.