

Orthopedic

Policy

Harvard Pilgrim reimburses contracted providers for the provision of orthopedic services.

Policy Definition

Orthopedics is the branch of medicine concerned with diseases, injuries, and conditions of the musculoskeletal system relating to the body's muscles and skeleton, and including the joints, ligaments, tendons, and nerves.

Prerequisite(s)

Applicable Harvard Pilgrim referral, notification and authorization policies apply. (Refer to [Referral, Notification and Authorization](#)) for more information.

HMO/POS/PPO

A referral is required for initial evaluation for HMO and in-network POS members.

Open Access HMO and POS

For [Open Access HMO and Open Access POS](#) products, no referral is required to see a contracted specialist.

Harvard Pilgrim Reimburses¹

HMO/POS/PPO

Surgical Procedures

- Surgical procedures at a single, all-inclusive (global) contract rate. The global period (zero, 10, 90 days) is determined using the CMS designation for each CPT code.
- Surgical procedures performed within the global period of another procedure by the same provider when it is a repeat procedure, a return trip to the OR for a staged procedure, or for an unrelated service or procedure (indicated by the appropriate modifier).

Medical Procedures

- Electrical stimulation and low-intensity ultrasound stimulation to aid bone healing
- Trigger point injections once per muscle group
- Joint fluid replacement
- Casting, strapping and/or supplies when:
 - Service consists of casting application or strapping only (e.g., a sprained ankle or knee)
 - No other procedure or treatment (i.e., surgical repair, reduction of fracture or joint dislocation) is performed or expected to be performed by the physician rendering the initial care
- Removal of casts, only if performed by a physician other than the physician rendering the initial care

Harvard Pilgrim Does Not Reimburse

HMO/POS/PPO

- Casting or strapping procedures when billed with another procedure or treatment (i.e., surgical repair, reduction of fracture or joint dislocation, other injury care)
- DeKompressor device
- Drugs, devices, treatments, procedures, laboratory and pathology tests that are experimental, unproven, or investigational and not supported by evidence based medicine and established peer reviewed scientific data
- Intradiscal electrothermal therapy (IDET)
- Insertion of pain catheters/pumps by surgeon during surgery
- Nucleoplasty
- Percutaneous laser disc decompression

- Percutaneous lumbar discectomy
- Post-operative visits within the global surgical period as defined by CMS for each surgical CPT code
- Separately for the use of robotic surgical systems and/or associated supplies

Member Cost-Sharing

Services subject to applicable member out-of-pocket cost (e.g., co-payment, coinsurance, deductible).

Provider Billing Guidelines and Documentation

Coding²

Code	Description	Comments
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (list separately in addition to code for primary procedure)	Not reimbursed
22526-22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single (22526) and each additional (22527)	Not reimbursed
22857	Total disc arthroplasty, (artificial disc) anterior approach, including discectomy to prepare interspace, (other than for decompression), lumbar, single interspace	Not reimbursed
22862	Revision, including replacement of total disc arthroplasty (artificial disc), anterior approach, lumbar, single interspace	Not reimbursed
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Not reimbursed

Modifiers

Bill	Use Modifier	Comments
Bilateral surgery	50	Refer to the <i>Bilateral Services and CPT Modifier 50 Payment Policy</i> for billing directives
Reduced service	52	Use with CPT code representing the service(s) performed
Attempted service (discontinued procedure)	53	Use with CPT code representing the service(s) performed
Decision for surgery	57	Use with evaluation and management code when appropriate
Staged or related procedure or service by the same physician during the postoperative period	58	Use with procedure performed within the global period of another surgery when appropriate
Assistant surgeon	80, 81, 82, or AS	<ul style="list-style-type: none"> • Use with CPT code representing the surgery(s) performed • Bill this modifier in the first modifier field
Co-surgery	62	<ul style="list-style-type: none"> • Use with CPT code representing the surgery(s) performed • Bill this modifier in the first modifier field
Team surgery	66	<ul style="list-style-type: none"> • Use with CPT code representing the surgery(s) performed • Attach operative notes • Bill this modifier in the first modifier field

PAYMENT POLICIES

Bill	Use Modifier	Comments
Repeat procedures by the same physician	76	Use with a repeat of a same procedure performed within the global period when appropriate
Return to the operating room for a related procedure during the postoperative period	78	Use when a related procedure requires a return trip to the OR by the same physician within the global period of the first surgery when appropriate
Unrelated procedure or service by the same physician during the postoperative period	79	Use when performing an unrelated procedure during the global period of a previous surgery

Other Information
General Billing

Bill an unlisted CPT code for services that do not have a specific CPT code describing the surgery; attach operative notes.

Bilateral Surgeries

Refer to the [Bilateral Services and CPT Modifier 50 Payment Policy](#) for billing directives.

Same Procedure Performed Multiple Times at the Same Session

Bill the same procedure performed multiple times at the same session on one line with a count.

Related Policies
Payment Policies

- Anesthesia
- Bilateral Services and CPT Modifier 50
- Evaluation and Management
- Injectable and Implantable Outpatient Drug
- Non-Covered Services
- Outpatient Surgery
- Outpatient Facility Fee Schedule
- Orthotic and Prosthetic Devices
- Surgery
- Tendon Sheath, Ligament Cyst, Carpal Tunnel and Tarsal Tunnel Injections
- Trigger Point Injections

Medical Policies

- New Technology Assessment and Non-Covered Services

PUBLICATION HISTORY

10/01/02	original documentation
07/01/03	added rotator cuff repair; bundling/unbundling coding combinations
02/01/03	clarified reimbursement code information for synovectomy and acromioclavicular dislocation
04/30/04	added vertebroplasty and kyphoplasty to procedures not reimbursed; annual coding update
01/31/05	removed documentation of code review edits from policy
01/31/06	annual coding update artificial disc and IDET added to non-reimbursed services;
10/31/06	annual review; kyphoplasty and vertebroplasty reimbursable for approved diagnosis codes; added modifier table
01/31/07	annual coding update
10/31/07	annual review, added modifier 58, 76, 78, and 79
01/31/08	annual coding update; added diagnosis codes covered for vertebro/kyphoplasty
07/31/08	bilateral billing update
10/31/08	annual review, minor updates to billing guidelines
01/31/09	annual coding update
10/15/09	annual review; minor edits for clarity; update to related policies
08/15/10	annual review; update to related policies

PAYMENT POLICIES

01/15/11	annual coding update
08/15/11	annual review; minor edits for clarity
01/01/12	removed First Seniority Freedom information from header
01/15/12	annual coding update
08/15/12	annual review; clarified robotic surgical systems not separately reimbursed
09/15/13	annual review; no changes
06/15/14	added <i>Connecticut Open Access HMO</i> referral information to Prerequisites
08/15/14	annual review; no changes
01/15/15	annual coding update
05/15/15	removed deleted codes; added <i>Vertebroplasty and Kyphoplasty</i> and <i>Artificial Cervical Disc</i> medical policies to related policies; CPT 22856, 22861 now reimbursed w/prior authorization, as of date of service 07/01/15
08/15/15	annual review; added clarification for robotic surgical systems
08/15/16	annual review; administrative edits
01/15/17	annual coding update
02/15/17	CPT 22858 now reimbursed w/prior authorization as of date of service 04/10/17; removed moderate sedation from billing guidelines; added anesthesia as a related payment policy
08/15/17	annual review; no changes
01/01/18	updated Open Access Product referral information under Prerequisites
09/04/18	annual review; administrative edits; added related medical policy
09/03/19	annual review; no changes
04/01/20	removed vertebroplasty and kyphoplasty for approved diagnosis; removed archived medical policies; added New Technology Assessment and Non-Covered Services Medical Policy as a related policy
09/01/20	annual review; updated related policies and Provider Billing and Guidelines
09/01/21	annual review; no changes

¹This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

²The table may not include all provider claim codes related to orthopedics.