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# Surgery

## Policy

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

## Policy Definition

*Surgery* is the branch of medical science that treats disease or injury by operative procedures.

## Prerequisite(s)

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

## HMO/POS/PPO

- A referral is required for specialist services for HMO and in-network POS members.
- An authorization is required for some surgical procedures. (For a list of surgical procedures that require authorization, refer to the [\*Prior Authorization Policy\*](#).)

## 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 Reimburses<sup>1</sup>

### HMO/POS/PPO

## Global Surgical Services

Services provided by another physician and/or health care professionals within the same group reporting the same Federal Tax Identification number will be included in the global surgical package reimbursement and not considered separately reimbursable.

Harvard Pilgrim reimburses surgical services at a single all-inclusive (global) contract rate. Payment includes:

- Pre-operative visits within 24 hours prior to a *major* surgery and on the same day a major or minor surgery is performed.
- Intra-operative services that are a usual and medically necessary part of the surgical procedure.
- Complications; all additional medical or surgical services rendered by the surgeon within the global period due to complications that do not require a re-operation or return trip to the operating room.
- Services for post-operative pain management rendered by the surgeon.
- Anesthesia services rendered by the surgeon.
- Miscellaneous services, such as:
  - Dressing changes
  - Other routine post-operative services
  - Removal of or change of, tracheostomy tubes
  - Removal of sutures, lines, wires and splints, etc.
  - Removal of urinary catheters, routine IV lines
- All post-operative visits, both inpatient and outpatient, within the global period related to the surgical procedure.
- Harvard Pilgrim follows the global period indicator as designated by CMS of 0, 10, 90 or YYY for each CPT code.

## Significant, Separately Identifiable E&M with Global Day Service—Same Day

Policy will apply to all professional services performed in an office place of service, when significant, separately identifiable E/M service (appended with 25 modifier) and any service that has a global period indicator as designated by CMS of 0, 10, 90 or YYY is performed on the same day, E&M service will be

reimbursed at 50% of the contracted allowable. When the E&M RVU value is greater than the procedure, the reduction will be applied to the global procedure code.

### **Bundled Services**

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Harvard Pilgrim reimburses only the most intensive CPT code when:

- A procedure is considered to be normally included as part of a more comprehensive code.
- A single, more comprehensive CPT code more accurately describes a group of procedures.
- If a procedure that is generally carried out as an integral part of a larger surgical procedure is performed alone and independent of other surgical services, it is reimbursable.

### **Multiple Procedures**

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- When multiple procedures are performed at the same session, the primary procedure is reimbursed at 100% of the allowable rate and all subsequent reimbursable procedures are paid at 50% of the allowable rate.
- Harvard Pilgrim determines the primary procedure based on the highest allowable rate, not the charge.

### **Bilateral Surgeries**

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- Bilateral surgeries are reimbursed at 150% of the allowable rate.
- Bilateral assistant surgeons are reimbursed at 16% of the allowable 150% amount.

### **Professional, Multiple and Bilateral Surgery Services Performed During the Same Operative Session**

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When a bilateral procedure code and surgical procedure(s) are performed at the same session and eligible for multiple procedure reduction, claim will be subject to multiple procedure reduction and bilateral procedure payment adjustment in accordance with Harvard Pilgrim payment policy. If the bilateral procedure is the secondary procedure, multiple procedure reduction and bilateral procedure payment adjustment will be applied.

### **Cosmetic and Reconstructive Surgery**

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Specific cosmetic and reconstructive procedures are reimbursable, with prior authorization, when medically necessary, and all Harvard Pilgrim coverage criteria are met. Indications include, but are not limited to:

- Repair of an accidental injury (e.g., repair of the face following a serious automobile accident).
- Improved function of a malformed body part.
- Treatment of severe burns.

For additional information, refer to the [Cosmetic, Reconstructive and Restorative Procedures Payment Policy](#).

### **Mohs Micrographic Surgery**

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- The removal of all gross tumor, surgical excision of tissue specimen, mapping, color coding of specimen, microscopic exam of the specimen, and complete histopathological preparation, including the first routine stain.
- Each stage of Mohs, up to five specimens and each additional specimen, after the first five performed at any stage, at 100% of the allowable for each CPT code submitted.
- Biopsy at the time of Mohs, if performed on a different site than the Mohs procedure.

### **Second Opinions**

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When requested by a member and/or his/her PCP/attending provider on a clinical decision related to a covered service such as diagnosis, treatment, consultation and surgery.

### **Assistant Surgeon Services**

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Harvard Pilgrim reimburses assistant surgeon services when the assistant at surgery is a physician, a physician assistant, clinical nurse specialist, or a nurse practitioner consistent with CMS' determination of approved procedure codes payable to an assistant surgeon.

- Assistant surgeon services are reimbursed at 16% of the fee schedule/allowable amount when modifier 80, 81 or 82 is appended.
- Secondary surgical procedures are reimbursed at 8% of the fee schedule/allowable amount when modifier 80, 81 or 82 is appended.
- Assistant surgeon services are reimbursed at 14% of the applicable allowable rate when modifier AS is appended.
- Secondary surgical services are reimbursed at 7% of the applicable allowable rate when modifier AS is appended.

**Assistant Surgeon Services (in Maine only)**

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Registered nurse/first assistants and physician assistants are reimbursed as assistant surgeons at a rate equal to 85% of the assistant surgeon 16% allowable rate. As of 07/01/2019 dates of service registered nurse/first assistants are reimbursed as assistant surgeons at a rate equal to 85% of the assistant surgeon 14% allowable rate.

**Co-Surgery**

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Co-surgery is reimbursed at 62.5% of the fee schedule/allowable amount.

**Team Surgery**

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Team surgery is reimbursed after individual consideration and review of operative notes according to the percentage of surgery performed by each respective surgeon.

**Attempted Service (discontinued procedure)**

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Attempted inpatient surgery is reimbursed at 50% of the fee schedule/allowable amount.

**Reduced Services**

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Reduced services are reimbursed at 50% of the fee schedule/allowable amount.

**Harvard Pilgrim Does Not Reimburse****HMO/POS/PPO**

- Anesthesia — Regional or general anesthesia services rendered by the surgeon
- Artificial lumbar disc (total disc replacement)
- Assistant surgical services rendered by residents or fellows
- Carotid body resection to relieve pulmonary symptoms
- Catheter lavage of a mammary duct(s) for collection of cytology specimen(s)
- Cochleostomy with neurovascular transplant for Meniere's disease
- Extracranial-intracranial (EC-IC) arterial bypass surgery
- Frozen section pathology services associated with Mohs surgery
- Handling or conveyance charges
- Hospital-mandated on-call services
- Insertion of pain catheters/pumps by surgeon during surgery
- Intradiscal electrothermal therapy (IDET)
- Laparoscopic band injections/fills billed with an E&M service
- Laser assisted uvulopalatoplasty
- Magnetic Resonance Guided Focused Ultrasound Ablation for uterine fibroids
- Medical and surgical supplies and/or items, such as, but not limited to, syringes, needles, local anesthetic, saline irrigation, dressings or gloves when billed in the office location
- More than one Assistant Surgeon per covered surgical service
- Partial ventriculectomy
- Penile revascularization surgery
- Physician standby services
- Pillar palatal implants for the treatment of snoring/obstructive sleep apnea
- Postoperative laparoscopic band injections/fills within the surgical global period

- Pulsed radiofrequency treatment
- Refractive eye surgery including laser surgery and orthokeratology for correction of myopia, hyperopia and astigmatism
- Restorative Obesity Surgery Endolumenal (ROSE procedure)
- Reversal of voluntary sterilization
- Routine venipuncture/collection of blood
- Second opinions from non-plan providers unless authorized in advance
- Separately for the use of robotic surgical systems and/or associated supplies
- Somnoplasty (also called radiofrequency volumetric tissue reduction and turbinate reduction)
- Surgical CPT codes and procedures classified as investigational
- Surgical trays
- Transvenous pulmonary embolectomy

### Member Cost-Sharing

Services subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible). Office copayments are not applied to routine post-operative visits that have an assigned number of days in the global period.

### Provider Billing Guidelines and Documentation

#### Coding<sup>2</sup>

Code	Description	Comment
A4550	Surgical trays	Not reimbursed
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Not reimbursed
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
36415	Routine venipuncture	Not reimbursed when billed with blood or related laboratory services or with E&M services
36416	Collection of capillary blood specimen	Not reimbursed
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)	Procedure is reimbursed when medically necessary after prior authorization
64653	Chemodenervation eccrine glands; other areas	Not reimbursed
65771	Radial keratotomy	Not reimbursed
99000, 99002	Handling or conveyance charges	Not reimbursed

## PAYMENT POLICIES

Code	Description	Comment
0163T, 0164T, 0165T	Total disc arthroplasty, removal of total disc arthroplasty, and revision of total disc	Not reimbursed
0071T, 0072T	Magnetic resonance guided focused ultrasound ablation for uterine fibroids	Not reimbursed
G0500	Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service (excluding biliary procedures) that the sedation supports (additional time may be reported with 99153, as appropriate)	Bill with CPT 43200-45398, HCPCS G0105 AND G0121
99151-99152	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	CPT 99152 not reimbursed when billed with CPT 43200-45398, HCPCS G0105 AND G0121. (See G0500)
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 intraservice time (List separately in addition to code for primary service)	Use in addition to G0500 or 99151, 99152
99155-99156	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 intraservice time	
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 intraservice time (List separately in addition to code for primary service)	Use in addition to 99155-99156

**Modifiers**

Use the following modifiers, as applicable:

Bill	Use Modifier	Other Information
Bilateral surgery	50	Refer to the Bilateral Services and CPT Modifier 50 Payment Policy for billing directives
Reduced service	52	Use with CPT code representing the surgery(s) performed
Attempted service (discontinued procedure)	53	
Decision for surgery	57	Use with evaluation and management code when appropriate
Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period	58	Use with procedure performed within the global period of another surgery when appropriate

## PAYMENT POLICIES

Bill	Use Modifier	Other Information
Assistant surgeon	80, 81, 82, or AS	<ul style="list-style-type: none"> <li>Use with CPT code representing the surgery(s) performed</li> <li>Bill this modifier in the first modifier field</li> </ul>
Co-surgery	62	<ul style="list-style-type: none"> <li>Use with CPT code representing the surgery(s) performed</li> <li>Bill this modifier in the first modifier field</li> </ul>
Team surgery	66	<ul style="list-style-type: none"> <li>Use with CPT code representing the surgery(s) performed</li> <li>Attach operative notes</li> <li>Bill this modifier in the first modifier field</li> </ul>
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 or other qualified health care professional 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
- Audiology
- Bilateral Services and CPT Modifier 50
- Certified Midwives, Nurse Practitioners, and Physician Assistants
- Coding Overview Payment Policy
- Cosmetic, Reconstructive and Restorative Procedures Payment Policy
- CPT and HCPCS Level II Modifiers<sup>1</sup>
- Dermatology
- Evaluation and Management
- Gastroenterology
- Gynecology
- Non-Covered Services Payment Policy
- Obstetric/Maternity Care
- Oral Surgery
- Orthopedic
- Podiatry
- Tendon Sheath, Ligament Cyst, Carpal Tunnel and Tarsal Tunnel Injections

PAYMENT POLICIES
 

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- Trigger Point Injections
- Unlisted/Unspecified Procedure Codes
- Vision Services

#### Medical Policies

- Cosmetic, Reconstructive and Restorative Procedures
- Moh's Micrographic Surgery Medical Policy
- New Technology Assessment and Non-Covered Services

#### Prior Authorization Policies

- Prior Authorization Policy

#### PUBLICATION HISTORY

01/01/01	original documentation
04/01/03	coding update; added bundling/unbundling coding combinations; emergency surgery notification changed to two business days
01/01/04	annual review; added attempted and reduced services reimbursement and billing information; Starred Surgical Procedures removed
04/30/04	annual coding review
10/31/04	removed chart of multiple surgical procedures reimbursed; added cosmetic surgery; separated co-surgery and team surgery; clarified reduced services; removed not separately reimbursed section; updated not reimbursed list; updated billing modifiers chart
04/30/05	annual coding review
01/31/06	annual review: added additional non-reimbursed services: somnoplasty; pillar palatal implants for the treatment of snoring/OSA; laser-assisted uvulopalatoplasty refractive eye surgery, etc.; 2006 coding updates
07/31/06	annual review; combined Mohs Payment Policy info to Surgery; added second opinion coverage; added gastric balloon and intestinal bypass for morbid obesity; isolated limb perfusion and percutaneous lumbar discectomy to FSEN not reimbursed procedures; new vertebroplasty/kyphoplasty reimbursement info effective 09/01/06
01/31/07	annual coding update
10/31/07	annual review; added no reimbursement for placement of pain pumps during surgery and lap band fills
01/31/08	annual coding update; added more diags covered for vertebro/kyphoplasty
07/31/08	bilateral billing update
10/31/08	annual review, added no coverage for ROSE procedure and magnetic resonance guided focused ultrasound ablation of uterine fibroids; provider liable for non-covered vertebrokyphoplasty diags
01/31/09	annual coding update
03/15/09	modifiers 80, 81, 82 and AS update
10/15/09	annual review; assistant surgery update — reduced services
01/15/10	updated multiple and bilateral surgery services; global surgical services same TIN, and global surgical services periods for YYY designated surgical codes.
08/15/10	annual review; minor edits for clarity, inclusion of additional policies to related policies
10/15/10	policy update; same day- significant, separately identifiable E/M service with surgery/diagnostic procedure
04/15/11	clarification of same day- significant, separately identifiable E/M service with global day service
08/15/11	annual review; minor edits for clarity; added sleeve gastrectomy reimbursement info — when medically necessary, after prior authorization — effective 07/01/11
01/01/12	removed First Seniority Freedom information from header
08/15/12	annual review; added robotic surgical systems, more than 1 assistant surgeon to Harvard Pilgrim Does Not Reimburse
01/15/13	annual coding update; updated verbiage for multiple procedures
04/15/13	updated same day significant, separately identifiable E&M service with global day care service
08/15/13	annual review; no changes
06/15/14	added <i>Connecticut Open Access HMO</i> referral information to Prerequisites
08/15/14	annual review; added detail to unlisted codes
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 and 22864 now reimbursed as of date of service 07/01/15
08/15/15	annual review; added supplies for robotic systems not separately reimbursed
08/15/16	annual review; no changes
01/15/17	annual coding update
02/15/17	added CPT 22858 now reimbursed w/prior authorization as of date of service 04/01/17; added moderate (conscious) sedation coding grid; added anesthesia as a related payment policy

PAYMENT POLICIES
 

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08/15/17	annual review; administrative edits; added general and regional anesthesia rendered by the surgeon, and added “lumbar” disc replacement to the Harvard Pilgrim does not reimburse section
02/01/18	annual coding update; updated Open Access Product referral information under Prerequisites
09/04/18	annual review; added clinical nurse specialist to sub header Assistant Surgeon Services of the Harvard Pilgrim Reimburses section; added Cosmetic, Reconstructive and Restorative Procedures Medical Policy to Related Policies section; clarified the Cosmetic and Reconstructive Surgery section and criteria for reimbursable cosmetic and reconstructive procedures; administrative edits
02/01/19	annual coding update
03/01/19	added definition of ‘Separate Procedures’
05/01/19	added change in reimbursement when modifier AS is appended as of date of service 07/01/19
09/03/19	annual review; administrative edits
10/01/19	added medical and surgical supplies and/or items to Harvard Pilgrim Does Not Reimburse
04/01/20	removed procedures; archived medical policy
09/01/20	annual review; administrative edits
09/01/21	annual review; removed sections for Unlisted Codes, Add-on Codes, Separate Procedures and Surgical Services Reimbursed Outside of the Global Rate When Billed with Appropriate Modifier; added Coding Overview, Non-Covered Services Payment Policies and Moh’s Micrographic Surgery Medical Policy to Related Policies; Administrative Edits to Moh’s Micrographic Surgery Section; administrative edits

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<sup>1</sup>This 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.

<sup>2</sup>The table may not include all provider claim codes related to surgery.