

SURGERY SERVICES

GLOBAL SURGERY POLICY

Many surgeries have a follow-up period during which charges for normal postoperative care are bundled into the global surgery fee. The global surgery follow-up period for each surgery is listed in the Fol-Up column in the Professional Services Fee Schedule.

Services and Supplies Included in the Global Surgery Policy

The following services and supplies are included in the global surgery follow-up period and are considered bundled into the surgical fee:

- The operation itself.
- Preoperative visits, in or out of the hospital, beginning on the day before the surgery.
- Services by the primary surgeon, in or out of the hospital, during the postoperative period.
- The following services:
 - Dressing changes;
 - Local incisional care and removal of operative packs;
 - Removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints;
 - Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes;
 - Change and removal of tracheostomy tubes; and
 - Cast room charges.
- Additional medical or surgical services required because of complications that don't require additional operating room procedures.

NOTE: Casting materials **aren't** part of the global surgery policy and are paid separately.

How to Apply the Follow-Up Period

The follow-up period applies to **any provider** who participated in the surgical procedure. These providers include:

- Surgeon or physician who performed any component of the surgery (The pre, intra, and/or postoperative care of the patient; identified by modifiers –56, –54 and –55)
- Assistant surgeon (identified by modifiers –80, –81 and –82)
- 2 surgeons (identified by modifier –62)
- Team surgeons (identified by modifier –66)
- Anesthesiologists and CRNAs

The follow-up period always applies to the following CPT® codes, unless modifier –22, –24, –25, –57, –58, –78 or –79 is appropriately used:

E/M Codes		Ophthalmological Codes
99211-99215	99304-99310	92012-92014
99218-99220	99315-99318	
99231-99239	99334-99337	
99291-99292	99347-99350	

Professional inpatient services (CPT® codes 99211-99223) are only payable during the follow-up period if they are performed on an emergency basis (for example, they aren't payable for scheduled hospital admissions).

Codes that are considered bundled **aren't payable** during the global surgery follow-up period.

Services and Supplies Not Included in the Global Surgery Policy

- The initial consultation or evaluation by the surgeon to determine the need for surgery.
- Services of other providers except where the surgeon and the other provider(s) agree on the transfer of care.
- Visits unrelated to the diagnosis of the surgical procedure performed, unless the visits occur due to surgery complications.
- Treatment for the underlying condition or an added course of treatment which isn't part of the normal surgical recovery.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Distinct surgical procedures during the postoperative period which aren't re-operations or treatment for complications (A new postoperative period begins with the subsequent procedure.)
- Treatment for postoperative complications which requires a return trip to the operating room.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Immunotherapy management for organ transplants.
- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the provider.

PRE, INTRA OR POSTOPERATIVE SERVICES

The insurer will allow separate payment when different providers perform the preoperative, intraoperative or postoperative components of the surgery. The modifiers (-54, -55 or -56) must be used. The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule.

If different providers perform different components of the surgery (pre, intra or postoperative care), the global surgery policy applies to each provider. For example, if the surgeon performing the operation transfers the patient to another provider for the postoperative care, the same global surgery policy, including the restrictions in the follow-up day period, applies to both providers.

MINOR SURGICAL PROCEDURES

For minor surgical procedures, the insurer only allows payment for an E/M office visit during the global period when:

- A documented, unrelated service is furnished during the postoperative period and modifier -24 is used, or
- The provider who performs the procedure is seeing the patient for the first time an initial new patient E/M service can be billed. This is considered a significant, separately identifiable service and modifier -25 must be used. Appropriate documentation must be made in the chart describing the E/M service.

Modifier -57, decision for surgery, isn't payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation isn't paid in addition to the procedure.

Modifier -57 is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

STANDARD MULTIPLE SURGERY POLICY

When multiple surgeries are performed on the same patient at the same operative session or on the same day, the total payment equals the sum of:

- **100%** of the global fee for the procedure or procedure group with the highest value, according to the fee schedule.
- **50%** of the global fee for the **second through fifth procedures** with the next highest values, according to the fee schedule.

More than 5 procedures require documentation and individual review to determine payment amount.

When different types of surgical procedures are performed on the patient on the same day, the payment policies will always be applied in the following sequence:

- Multiple endoscopy procedures.
- Other modifier policies.
- Standard multiple surgery policy.

When the same surgical procedure is performed on multiple levels, each level must be billed as a separate line item. See the Bilateral Procedures Policy for additional instructions on billing bilateral procedures.

BILATERAL PROCEDURES POLICY

Bilateral surgeries should be billed as 2 line items. Modifier –50 must be applied to the second line item. The second line item is paid at the lesser of the billed charge or 50% of the fee schedule maximum. Bilateral procedures are considered 1 procedure when determining the highest valued procedure before applying multiple surgery rules.



Check the Professional Services Fee Schedule to see if modifier –50 is valid with the procedure performed.

Example: Bilateral Procedure

Line Item	CPT® Code/Modifier	Maximum Payment (nonfacility setting)	Bilateral Policy Applied	Allowed Amount
1	64721	\$678.47		\$678.47 ⁽¹⁾
2	64721-50	\$678.47	\$339.24 ⁽²⁾	\$339.24
Total Allowed Amount in Nonfacility Setting:				\$1017.71 ⁽³⁾

- (1) Allowed amount for the highest valued procedure is the fee schedule maximum.
- (2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
- (3) Represents total allowable amount.

Example: Bilateral Procedure and Multiple Procedures

Line Item	CPT® Code/Mod	Max Payment (nonfac setting)	Bilateral Applied	Multiple Applied	Allowed Amount
1	63042	\$2,068.61			\$2,068.61 ⁽¹⁾
2	63042-50	\$2,068.61	\$1,034.31 ⁽²⁾		\$1,034.31
					subtotal \$3,102.92 ⁽³⁾
3	22612-51	\$2,543.98		\$1,271.99 ⁽⁴⁾	\$1,271.99
Total Allowed Amount in Nonfacility Setting:					\$4,374.91 ⁽⁵⁾

- (1) Allowed amount for the highest valued procedure is the fee schedule maximum.
- (2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
- (3) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.
- (4) The third line item billed with modifier –51 is paid at 50% of the maximum payment.
- (5) Represents total allowable amount.

ENDOSCOPY PROCEDURES POLICY

For the purpose of these payment policies, endoscopy will be used to refer to any invasive procedure performed with the use of a fiberoptic scope or other similar instrument.

Payment isn't allowed for an E/M office visit on the same day as a diagnostic or surgical endoscopic procedure unless a documented, separately identifiable service is provided and modifier –25 is used.

Endoscopy procedures are grouped into clinically related families. Each endoscopy family contains a base procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an endoscopy family is listed in the Endo Base column in the Professional Services Fee Schedule. Base procedures and their family members are also identified in **Appendix A**, Endoscopy Families.

When multiple endoscopy procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

1. The endoscopy procedure with the highest dollar value is 100% of the fee schedule value.
2. For subsequent endoscopy procedures, payment is the difference between the family member and the base fee.
3. When the fee for the family member is less than the base fee, the payment is \$0.00 (see Example 2).
4. No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an endoscopic group. If more than 1 endoscopic group or other nonendoscopy procedure is billed for the same patient on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see Examples 3 and 4).

Multiple endoscopies that aren't related (Each is a separate and unrelated procedure) are priced as follows:

1. 100% for each unrelated procedure, then
2. Apply the standard multiple surgery policy

Example 1: 2 Endoscopy Procedures in the Same Family

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Allowed Amount
Base ⁽¹⁾	29805	\$ 751.52	\$ 000.00 ⁽²⁾	
1	29822	\$ 918.64	\$ 167.12 ⁽⁴⁾	\$ 167.12 ⁽⁵⁾
2	29826	\$ 1,068.06	\$ 1,068.06 ⁽³⁾	\$ 1,068.06 ⁽⁵⁾
Total Allowed Amount in Nonfacility Setting:				\$ 1,235.18 ⁽⁶⁾

- (1) Base code listed is for reference only (not included on bill form).
- (2) Payment isn't allowed for a base code when a family member is billed.
- (3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
- (4) Allowed amount for other procedures in the same endoscopy family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
- (5) Amount allowed under the endoscopy policy.
- (6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy doesn't apply because only 1 family of endoscopic procedures was billed.

Example 2: Endoscopy Family Member with Fee Less than Base Procedure

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Allowed Amount
Base ⁽¹⁾	43235	\$488.65		
1	43241	\$ 253.22	\$ 000.00 ⁽²⁾	
2	43251	\$ 359.16	\$ 359.16 ⁽³⁾	\$ 359.16 ⁽⁴⁾
Total Allowed Amount in Nonfacility Setting:				\$ 359.16 ⁽⁵⁾

- (1) Base code listed is for reference only (not included on bill form).
- (2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
- (3) When the fee schedule maximum for a code in an endoscopy family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to \$0.00.
- (4) Allowed amount under the endoscopy policy.
- (5) Represents total allowed amount. Standard multiple surgery policy doesn't apply because only 1 endoscopic group was billed.

Example 3: 2 Surgical Procedures Billed with an Endoscopic Group (highest fee)

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	11402	\$ 260.65		\$ 130.33 ⁽⁵⁾
2	11406	\$ 481.46		\$ 240.73 ⁽⁵⁾
Base ⁽¹⁾	29830	\$ 724.95		
3	29835	\$ 808.52	\$ 83.57 ⁽³⁾	\$ 83.57 ⁽⁴⁾
4	29838	\$ 946.87	\$ 946.87 ⁽²⁾	\$ 946.87 ⁽⁴⁾
Total Allowed Amount in Nonfacility Setting:				\$ 1401.50 ⁽⁶⁾

- (1) Base code listed is for reference only (not included on bill form).
- (2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.
- (3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
- (4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100%.
- (5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
- (6) Represents total allowed amount after applying all applicable global surgery policies.

Example 4: 1 Surgical Procedure (highest fee) Billed with an Endoscopic Group

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	23412	\$ 1,370.22		\$ 1,370.22 ⁽⁴⁾
Base ⁽¹⁾	29805	\$ 751.52		
3	29826	\$ 1,068.06	\$ 316.54 ⁽³⁾	\$ 158.27 ⁽⁵⁾
4	29824	\$ 1,078.02	\$1,078.02 ⁽²⁾	\$ 539.01 ⁽⁵⁾
Total Allowed Amount in Nonfacility Setting:				\$ 2,067.50 ⁽⁶⁾

- (1) Base code listed is for reference only (not included on bill form).
- (2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.
- (3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
- (4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100%.
- (5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
- (6) Represents total allowed amount after applying all applicable global surgery policies.

MICROSURGERY

CPT® code 69990 is an add-on surgical code that indicates an operative microscope has been used. As an add-on code, it isn't subject to multiple surgery rules.

CPT® code 69990 isn't payable when:

- Using magnifying loupes or other corrected vision devices, or
- Use of the operative microscope is an inclusive component of the procedure, (for example the procedure description specifies that microsurgical techniques are used), or
- Another code describes the same procedure being done with an operative microscope. For example, CPT® code 69990 can't be billed with CPT® code 31535 because CPT® code 31536 describes the same procedure using an operating microscope. The table below contains a complete list of all such codes.

CPT® Codes Not Allowed with CPT® 69990

CPT® Code	CPT® Code	CPT® Code	CPT® Code
15756-15758	26551-26554	31561	63075-63078
15842	26556	31571	64727
19364	31526	43116	64820-64823
19368	31531	43496	65091-68850
20955-20962	31536	49906	
20969-20973	31541-31546	61548	

SPINAL INJECTION POLICY

Injection procedures are divided into 4 categories; injection procedures that:

1. Require fluoroscopy.
2. Injections that include fluoroscopy or CT guidance in their descriptions.
3. May be done without fluoroscopy when performed at a certified or accredited facility by a physician with privileges to perform the procedure at that facility. These procedures require fluoroscopy if they aren't performed at a certified or accredited facility.
4. Don't require fluoroscopy.

Definition of Certified or Accredited Facility

L&I defines a certified or accredited facility as a facility or office that has certification or accreditation from 1 of the following organizations:

1. Medicare (CMS - Centers for Medicare and Medicaid Services)
2. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
3. Accreditation Association for Ambulatory Health Care (AAAHC)
4. American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
5. American Osteopathic Association (AOA)
6. Commission on Accreditation of Rehabilitation Facilities (CARF)

Spinal Injection Procedures that Require Fluoroscopy

CPT® Code	CPT® Fluoroscopy Codes ^{(1),(2)}
62268	77002, 77012, 76942
62269	77002, 77012, 76942
62281	77003, 72275
62282	77003, 72275
62284	77003, 77012, 76942, 72240, 72255, 72265, 72270
62290	72295
62291	72285
62292	72295
62294	77002, 77003, 77012, 75705
62310	77003, 72275
62311	77003, 72275
62318	77003, 72275
62319	77003, 72275

- (1) One of these fluoroscopy codes must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied.
- (2) Only 1 of these codes may be billed for each injection.

Spinal Injection Procedures that Include Fluoroscopy, Ultrasound or CT in the Description

Paravertebral facet joint injections now include fluoroscopic or CT guidance as part of the description. Fluoroscopic, ultrasound or CT guidance can't be billed separately.

CPT® Code	CPT® Code
64479	0213T
64480	0214T
64483	0215T
64484	0216T
64490	0217T
64491	0218T
64492	0228T
64493	0229T
64494	0230T
64495	0231T

Spinal Injection Procedures that May Be Done Without Fluoroscopy

Interlaminar epidural steroid injections may be performed without fluoroscopy if performed at a certified or accredited facility by a provider with privileges to perform the procedure at that facility. The provider must decide whether to use fluoroscopy based on sound medical practice.

To be payable, these spinal injections must include a facility place of service code and documentation that the procedure was performed at a certified or accredited facility.

CPT® Code
62310
62311
62318
62319

Spinal Injection Procedures that Don't Require Fluoroscopy

CPT® Code
62270
62272
62273

Payment Methods for Spinal Injection Procedures

Provider Type	Procedure Type	Payment Method
Physician or CRNA/ARNP	Injection ⁽³⁾	-26 Component of Professional Services Fee Schedule
	Radiology	-26 Component of Professional Services Fee Schedule
Radiology Facility	Injection	No Facility Payment
	Radiology	-TC Component of Professional Services Fee Schedule
Hospital ⁽¹⁾	Injection	APC or POAC
	Radiology ⁽²⁾	APC or -TC Component of Professional Services Fee Schedule
ASC	Injection	ASC Fee Schedule
	Radiology	-TC Component is a bundled service

- (1) Payment method depends on a hospital's classification.
- (2) Radiology codes may be packaged with the injection procedure.
- (3) A separate payment for the injection **won't be made** when computed tomography is used for imaging unless documentation demonstrating medical necessity is provided.

REGISTERED NURSES AS SURGICAL ASSISTANTS

Licensed registered nurses may be paid to perform surgical assistant services if they submit the following documents to L&I along with their completed provider application.

1. A photocopy of her/his valid and current registered nurse license, and
2. A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Payment for these services is 90% of the allowed fee that would be paid to an assistant surgeon.

PROCEDURES PERFORMED IN A PHYSICIAN'S OFFICE

Procedures performed in a provider's office are paid at nonfacility rates that include office expenses. Modifier –SU denotes the use of facility and equipment while performing a procedure in a provider's office. Services billed with an –SU modifier aren't covered.

Providers' offices must meet ASC requirements to qualify for separate facility payments. Refer to Chapter [296-23B WAC](#) for information about the requirements.

MISCELLANEOUS

Angioscopy

Payment for angioscopies CPT® code 35400 is limited to only 1 unit based on its complete code description encompassing multiple vessels. The work involved with varying numbers of vessels was incorporated in the RVUs.

Autologous Chondrocyte Implant

The insurer **may cover** autologous chondrocyte implant (ACI) when all of the guidelines are met. ACI requires **prior authorization**.

In addition to the clinical guidelines for the procedure, the surgeon must:

- Have received training through Genzyme Biosurgery and
- Have performed or assisted with 5 ACI procedures or
- Perform ACI under the direct supervision and control of a surgeon who has performed 5 or more ACI procedures.

The appropriate CPT® code for the implant is 27412. Use CPT® code 29870 for harvesting the chondrocytes.

If the procedure is authorized, the insurer will pay US Bioservices for Carticel® (autologous cultured chondrocytes). For more information, go to

<http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/autoChondImplant.asp>

Bone Morphogenic Protein

The insurer **may cover** the use of bone morphogenic protein as an alternative to autograft in recalcitrant long bone nonunion where use of autograft isn't feasible and alternative treatments have failed. It may also cover its use for spinal fusions in patients with degenerative disc disease at 1 level from L4-S1.

CPT® codes used depend on the specific procedure being performed.

All of the criteria and guidelines must be met before the insurer will authorize the procedures. For more information, go to

<http://www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonemorphogenics.aspx>

In addition, lumbar fusion guidelines must be met. For more information, go to <http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/TreatGuide/default.asp>

Bone Growth Stimulators

The insurer, with **prior authorization**, pays for bone growth stimulators for specific conditions when proper and necessary, including:

- Noninvasive or external stimulators including those that create a small electrical current and those that deliver a low intensity ultrasonic wave to the fracture, and
- Implanted electrical stimulators that supply a direct current to the bone.

For more information, go to

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonegrowthstimulators.asp>

Billing Codes for Bone Growth Stimulators

Billing Code	Description	Prior Auth.
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal application	Required
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal application	Required
E0749	Osteogenesis stimulator, electrical (surgically implanted)	Required
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive	Required

Botulinum Toxin

The insurer covers botulinum toxin injections (Botox[®]: BTX-A, Myobloc[®]: BTX-B) **with prior authorization** for the following indications when it is proper and necessary:

- Blepharospasm
- Primary axillary hyperhidrosis
- Cervical dystonia (spasmodic torticollis)
- Strabismus
- Hemifacial spasm
- Torsion dystonia (idiopathic/symptomatic)
- Laryngeal or spasmodic dysphonia
- Torticollis, unspecified
- Orofacial dyskinesia
- Writer's cramp
- Oromandibular dystonia

Patients must have failed conservative treatment such as other medications and physical therapy before Botox will be authorized.

Noncovered Indications

The insurer won't authorize payment for BTX injections for other off-label indications.

Criteria for Additional Injections

The insurer may authorize 1 subsequent injection session administered 90 days after the initial session if the first BTX session produced an adequate, functional response. Providers must submit documents describing the patient's response to BTX following a session of injections. No more than 2 injections per individual will be authorized due to risk of antibody development and decrease in response.

For more information, go to

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/botulinumtoxin.asp>

Closure of Enterostomy

Closures of enterostomy **aren't payable** with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy. CPT® code 44139 will be denied if it is billed with CPT® code 44625 or 44626.

Epidural Adhesiolysis

The insurer, with **prior authorization**, pays for epidural adhesiolysis using the 1 day protocol but doesn't pay for the 3 day protocol. Epidural adhesiolysis is also known as percutaneous lysis of epidural adhesions, epidural decompressive neuroplasty, and Racz neurolysis. Workers must meet the following criteria:

- The worker has experienced acute low back pain or acute exacerbation of chronic low back pain of no more than 6 months duration.
- The provider intends to conduct the adhesiolysis in order to administer drugs closer to a nerve.
- The provider documents strong suspicion of adhesions blocking access to the nerve.
- Adhesions blocking access to the nerve have been identified by Gallium MRI or Fluoroscopy during epidural steroid injections.

For more information, go to

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Epiduraladhesiolysis.asp>

Meniscal Allograft Transplantation

The insurer, with **prior authorization**, may cover meniscal allograft transplantation when all of the guidelines are met.

In addition to the clinical guidelines for the procedure, the surgeon must:

- Have performed or assisted with 5 meniscal allograft transplants or
- Perform the transplant under the direct supervision and control of a surgeon who has performed 5 or more transplants.

For more information, go to

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/CovMedDev/SpecCovDec/Meniscal.asp>