



# Ambulatory Surgery – Professional Payment Policy

(Same-day surgical procedures)

## **Policy**

Fallon Community Health Plan (FCHP) reimburses medically necessary professional surgical services provided in either an Outpatient Surgical Service (Non-ASC) or an ASC-designated facility.

## **Definition**

**Outpatient Surgical Services** typically do not require an overnight stay. These services may include pain management and certain diagnostic services that can be performed in an outpatient setting. These services are billed utilizing CPT surgical codes. Providers are reimbursed subject to all FCHP outpatient billing and payment, bundling and global package rules. FCHP refers to a surgical day services (SDS) procedures listing to identify surgical services that are covered. Additionally, outpatient surgical services are defined as major or minor.

**Ambulatory Surgical Centers (ASCs)** also specialize in providing surgery, pain management and certain diagnostic services in an outpatient setting. These services are also billed utilizing CPT surgical codes.

## **Benefits application**

### **Commercial**

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care

### **Senior Plan**

- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®

## **Reimbursement**

FCHP *does reimburse* for outpatient/ambulatory surgery/significant procedures as per contractual agreement.

Bilateral surgeries are typically reimbursed at 150% of the contracted allowable rate for the procedure when billed on one line with the -50 modifier appended to the procedure code. 100% to be paid for first side, 50% to be paid for second side.

FCHP requires operative notes for claims submitted in amounts equal to or greater than \$1,000.

FCHP *does not reimburse:*

- Needle electromyography (95867-95872), intraoperative neurophysiology testing (95920), or short-latency somatosensory/central motor evoked potential studies (95925-95929) billed by the primary surgeon.
- Ambulatory surgical day procedures if they are deemed:
  - ✓ Not medically necessary.
  - ✓ Those services that require preauthorization by the Plan when authorization was not obtained. The member may not be billed for non-authorized services when performed by contracted providers at contracted facilities.
  - ✓ Services provided by residents.

## **Referral/notification/preauthorization requirements**

Preauthorization is required for select ambulatory/same-day surgical procedures and/or services.

The ordering physician is required to obtain preauthorization for:

- Unlisted CPT codes.
- The applicable codes found on the List of Procedures Requiring Preauthorization located in the Managing Patient Care section of the *Provider Manual* under PCP Referral and Plan Preauthorization Process.

## **Billing/coding guidelines**

*Two providers – same surgery*

- If one physician performs the surgery and another renders the post-op care, they may each bill with appropriate modifiers affixed to the claim.

*Bundled services*

- FCHP only reimburses the more “intensive” CPT code when a procedure is considered to be part of a more comprehensive procedure or when a single more comprehensive CPT code more accurately describes a group of procedures.

*Multiple surgical services*

- When multiple surgical services are performed at the same session, the procedure with the highest intensity is reimbursed at 100% of the contracted allowable rate and all subsequent reimbursable procedures are paid at 50% of the allowable rate up to 5 procedures, or pursuant to contractual agreement.

*Add-on codes*

- Add-on codes are reimbursed at 100% of the contracted allowable rate and are NOT subject to the multiple surgical services rule for reduction in payment.
- Add-on codes cannot be billed alone.

*Assistant at surgery - Physician*

- Reimbursement is made at 16% of the surgeon’s contracted allowable rate.

*Co-surgery*

- If Medicare allows payment, reimbursement is made at 63% of the contracted allowable rate for each provider.
- Separate operative notes are required from each provider documenting their distinctly separate portions of the procedure.

#### *Attempted surgical procedure*

- FCHP will review supporting documentation and will reimburse at a reduced rate of the contractual fee schedule based on the level of services provided when modifier -53 is affixed to indicate discontinued outpatient procedures; the appropriate modifier must be appended and supporting documentation should be submitted with the claim.

#### *Reduced surgical procedures*

- When modifier -52 is affixed to indicate reduced services, FCHP will reimburse at 50% of the contracted allowable rate.

#### *Modifiers*

The following is a list of modifiers often used in surgical billing for both ASC and Non-ASC:

- -24 services unrelated to surgical service during post-operative period. Use modifier -24 for post-op services when billing for services that are unrelated to the surgical procedure; notes are required.
- -25 Significant separately identifiable service on the same day as another E&M
- -50 Bilateral procedure
- -51 Multiple procedures (not for Medicare)
- -52 Reduced services
- -53 Discontinued service (Professional side only; Facility uses 73/74)
- -54 Surgical Service only
- -55 Post-op surgical service only
- -56 Pre-op surgical service only
- -57 E&M service provided on same day as major surgery
- -58 Staged or related procedure or service by same physician on same day
- -59 Distinct procedural service
- -62 Two surgeons
- -66 Team surgery
- -76 Repeat procedure or service by same physician
- -77 Repeat procedure by another physician
- -78 Unplanned return to the operating/procedure room for a related procedure during the postoperative period
- -79 Unrelated procedure or service by the same physician on the same day
- -80 Assistant at Surgery
- -82 Qualified Resident
- -AS Services provided by PA, NP, or CNS

### **Place of service**

This policy applies to professional services that are submitted with a place of service -22 indicating an Outpatient Hospital or -24 indicating an Ambulatory Surgical Center (ASC).

### **Policy history**

Origination date: 11/01/08  
Previous revision date(s): N/A  
Connection issue date & details: 07/01/09 - Clarified language in the Reimbursement, Referral/notification/preauthorization requirements and Billing/coding sections.

*This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for FCHP. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. FCHP reserves the right to apply this payment policy to all FCHP companies and subsidiaries.*