Outpatient Surgery Facility Payment Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)
☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting outpatient facilities. For information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, click here.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY
Tufts Health Plan covers medically necessary surgical services including surgical day care (SDC) rendered in an outpatient facility, as described below. Tufts Health utilizes InterQual® criteria to determine the appropriateness of the requested level, or setting, of service (e.g., inpatient vs. SDC).

For information regarding ambulatory surgical centers, click here.

GENERAL BENEFIT INFORMATION
Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider website or by contacting Commercial Provider Services.

The following table indicates the type of copayment that will be applied to the claim based on the member’s benefit.

<table>
<thead>
<tr>
<th>Services Rendered</th>
<th>Cost Share (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor operating room (OR) services</td>
<td>No copayment</td>
</tr>
<tr>
<td>Surgical procedure done at outpatient facility</td>
<td>SDC copayment</td>
</tr>
<tr>
<td>SDC resulting in an inpatient stay in the same facility, same day or next day</td>
<td>No SDC copayment Inpatient copayment</td>
</tr>
</tbody>
</table>

Reconstructive and Cosmetic Procedures
Services including surgery, procedures, supplies, medications or appliances used to change body structures in order to improve appearance and/or self-esteem are considered cosmetic and are not covered. Refer to the Reconstructive and Cosmetic Surgery Medical Necessity Guidelines for additional information on coverage criteria.

Investigational Procedures
Surgical CPT codes and procedures classified as investigational in nature are not covered. Refer to the Noncovered Investigational Services Medical Necessity Guidelines for more information.

AUTHORIZATION REQUIREMENTS
Providers must request prior authorization for interventional pain management, lumbar and cervical spine surgeries through NIA. Providers can contact NIA for prior authorization through RadMD.

Refer to the Spinal Conditions Management Program for more information. For a list of CPT codes subject to prior authorization, refer to the Spinal Conditions Management Program Prior Authorization Code Matrix.

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
Inpatient notification is required for all inpatient admissions prior to services being rendered, and for outpatient surgical services that result in an inpatient admission. The admitting provider or facility should submit an inpatient notification for the patient at the time of admission.

**Note:** Facility claims will be denied if the referral to the specialist/surgeon has not been obtained.

**Reconstructive and Cosmetic Procedures**

With appropriate authorization, Tufts Health Plan covers surgical services to improve the function of a body part or organ that has been adversely affected by illness, injury or congenital defect.

Prior authorization is required for procedures which have both a cosmetic and functional component, or when the issue of whether the procedure meets Tufts Health Plan’s definition of cosmetic and/or reconstruction is in question. Refer to the Reconstructive and Cosmetic Surgery Medical Necessity for additional information on coverage criteria.

**COMPENSATION/REIMBURSEMENT INFORMATION**

Procedures or services that are not appropriate to be performed in an office setting will deny. For a list of these procedure codes, refer to CMS’s National Physician Relative Value File and Tufts Health Plan’s Services Inappropriate to be Performed in an Outpatient Setting list.

**Ancillary Services**

Compensation to the facility is based on the surgical procedure code(s) submitted on the claim. Ancillary charges are included in the surgical compensation rate. Ancillary lines will either be removed from the claim or denied.

**Bilateral and Multiple Surgical Procedures**

Tufts Health Plan applies multiple surgical procedures reduction when the same provider performs two or more surgical procedures (including procedures performed bilaterally and/or different procedures in multiple compartments of the same joint) on the same member within the same operative session. Refer to the Bilateral and Multiple Surgical Procedures Professional Payment Policy for additional information on multiple surgical procedures reduction.

**Implantable Neurostimulator Electrode**

Effective for dates of service on or after January 1, 2018, Tufts Health Plan will not routinely compensate L8680 (implantable neurostimulator electrode, each) when billed with 63650 (percutaneous implantation of neurostimulator electrode array, epidural).

**Serious Reportable Events (“Never Events”)**

Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate for any procedure when billed with modifier PA (surgical or other invasive procedure on wrong body part), PB (surgical or other invasive procedure on wrong patient), or PC (wrong surgery or other invasive procedure on patient). Refer to the DRG and Non-DRG Inpatient payment policies for more information on “never events.”

**Surgical Day Care (SDC)/ Minor Operating Room Services**

Surgical procedure codes are paid according to the fee assigned to the corresponding surgical level assigned by Tufts Health Plan. Tufts Health Plan levels (A, B, Z and 1–9) are based on the complexity involved in performing and administering the service.

The table below identifies the HOSFS level and corresponding description.

<table>
<thead>
<tr>
<th>HOSFS Level</th>
<th>Tufts Health Plan Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Minor OR</td>
</tr>
<tr>
<td>B</td>
<td>Minor OR</td>
</tr>
<tr>
<td>Z</td>
<td>Minor OR</td>
</tr>
<tr>
<td>1</td>
<td>Minor OR</td>
</tr>
<tr>
<td>2</td>
<td>Outpatient surgery/SDC</td>
</tr>
<tr>
<td>3</td>
<td>Outpatient surgery/SDC</td>
</tr>
<tr>
<td>4</td>
<td>Outpatient surgery/SDC</td>
</tr>
<tr>
<td>5</td>
<td>Outpatient surgery/SDC</td>
</tr>
<tr>
<td>6</td>
<td>Outpatient surgery/SDC</td>
</tr>
</tbody>
</table>
Levels 2–9 are subject to a SDC copayment based on the member’s benefit plan.

Contracting facilities receive a copy of the fee schedule (HOSFS) on an annual basis. The fee schedule identifies the SDC procedure codes and their assigned levels. The HOSFS applies to facilities only.

Surgical leveling does not apply to inpatient services. When a surgical procedure results in an inpatient admission, compensation will be based on the inpatient contracted rate.

**Surgical Global Day Period**

Surgical procedures are assigned a global day period of 0, 10 or 90 days by CMS based on the complexity of the procedure. Services rendered within the assigned specified numbers of global days, including evaluation and management services (E&M), are considered inclusive to the primary procedure.

**Unleveled Procedure Codes**

Surgical procedure codes that do not have an assigned payment level (e.g., new procedure codes) will pend for Medical Director review. Upon review, a level is assigned, and the claim is paid at that payment level.

**ADDITIONAL RESOURCES**

- [Claims Submission Payment Policy](#)
- [Emergency Department Services Facility Payment Policy](#)

**DOCUMENT HISTORY**

- June 2018: Template updates
- November 2017: Added edits for implantable neurostimulator electrode effective for dates of service on or after January 1, 2018.
- July 2017: Added serious reportable events modifiers edit, effective for dates of service on or after October 1, 2017
- January 2017: Template updates
- September 2015: Template updates
- July 2015: Added information regarding the Spinal Conditions Prior Authorization Program effective for dates of service on or after August 1, 2015, template updates
- January 2015: Added Revenue Codes 0681-0684, 0689, 1000-1002 accepted when submitted electronically without a corresponding CPT and/or HCPCS procedure code
- August 2014: Policy reviewed, added level Z for SDC and minor OR services, minor formatting changes, moved information about unlisted procedure codes to the Claims Submission Payment Policy; template updates
- September 2013: Template conversion
- November 2012: Added information regarding the submission and processing of unlisted procedures for claims dates of service on or after January 1, 2013.
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- October 2011: Template updates
- July 2010: Removed language pertaining to the collapse of ancillary services into the surgical procedure code as this logic is no longer utilized
- June 2008: Clarified the SDC Roll-Back process by including the HOSFS List

**AUDIT AND DISCLAIMER INFORMATION**

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will
be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.