Surgery Professional 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)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

Applies to the following Tufts Health Public Plans products:

- ☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers rendering professional surgical services..

In addition to the specific information contained in this policy, providers must adhere to the 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 professional components of surgical services, in accordance with the member's benefits.

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 portal or by contacting Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

Investigational Procedures

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

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained.

All inpatient admissions require inpatient notification prior to services being rendered. Professional claims will be denied if the notification to the hospital has not been obtained by the facility. It is the responsibility of the admitting practitioner and/or facility to obtain the appropriate authorization(s), as necessary. For more information, refer to the Referrals, Prior Authorizations and Notifications chapters of the Commercial, Senior Products, and Tufts Health Public Plans provider manuals.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

Commercial and Tufts Health Public Plans

Spinal Conditions Management and Joint Surgery

Prior authorization is required for interventional pain management, lumbar and cervical spine surgeries, and joint surgeries through National Imaging Associates (NIA). Refer to the Spinal Conditions Management Program and Joint Surgery Program for more information.

For a comprehensive list of surgical services that require prior authorization, refer to the Medical Necessity Guidelines in the Provider Resource Center.

Senior Products

For a list of procedures, services, and items requiring prior authorization or notification for Senior Products Senior Products members, refer to the following:

- Tufts Medicare Preferred HMO: Prior Authorization and Inpatient Notification List
- Tufts Health Plan SCO: Prior Authorization and Notification lists

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

Assistant Surgeons, Co-Surgeons and Team Surgery

In alignment with CMS and the American College of Surgeons, Tufts Health Plan considers compensation for services requiring multiple surgeons when the procedure warrants. Any appropriate modifier(s) must be appended to compensate the claim(s) according to the services rendered. Refer to CMS for more information.

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 reductions.

Implantable Neurostimulator Electrode

Tufts Health Plan does not routinely compensate L8680 (implantable neurostimulator electrode, each) when billed with 63650 (percutaneous implantation of neurostimulator electrode array, epidural).

Nonphysician Practitioners

Tufts Health Plan does not routinely compensate a major surgical procedure when billed by a non-physician practitioner (NPP) and modifier 80, 81, 82 or AS is not appended to the claim line.

Photosensitive Drugs and Ocular Photodynamic Therapy

Tufts Health Plan does not routinely compensate 67221-67225 (destruction of localized lesion of choroids) if billed and J3396 (verteporfin) has not been billed or paid for the same date of service.

Place of Service

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.

Robotic Surgical Systems

Tufts Health Plan does not routinely provide separate compensation for the use of a robotic surgical system (S2900).

Surgical Global Day Period

Global surgery includes all necessary services normally furnished by the surgeon before, during and after a surgical procedure. Global surgery applies only to surgical procedures that have post-operative

global periods of 0, 10, 30[3] and 90 days. The global surgery concept applies only to primary surgeons and co-surgeons. Global surgery includes preoperative and same day E&M visits after the decision is made to operate and all post-operative E&M visits and procedures for 10-, 30- and 90-day global surgeries related to the primary procedure. Refer to the AMA CPT Manual for additional information.

Surgical Package Compensation
Some services are included in the global surgical package and are not considered separately payable when billed by the same provider or another provider within the same provider group (same tax ID number).

Note: Certain services may be considered for separate compensation when the appropriate modifier is appended.

Split Surgical Services
Providers rendering a portion of the surgical service (pre-, intra- or post-operative) should indicate the portion of services rendered by appending the appropriate modifier. Providers will be compensated accordingly for the specific portion of services rendered.

If a surgical claim is submitted without a modifier appended, it is assumed that the same provider performed the pre-, intra- and post-operative services. Claims that do not have an appended modifier will be processed and compensated at the surgical rate.

Senior Products only
Bariatric Surgery for Treatment of Morbid Obesity
Tufts Health Plan does not routinely compensate 43644, 43645, 43770, 43775, 43845-43847 (gastric restrictive procedure, with gastric bypass) when billed without a primary diagnosis of morbid obesity.

ADDITIONAL RESOURCES

- Emergency Department Services Professional Payment Policy
- DRG Inpatient Facility Payment Policy
- Non-DRG Inpatient Facility Payment Policy
- Noncovered/Nonreimbursable Services Payment Policy
- Noncovered Investigational Services
- Serious Reportable Events Payment Policy

DOCUMENT HISTORY

- December 2020: Policy reviewed by committee; added applicable Tufts Health Public Plans content; clarified compensation information for robotic surgical assistance; consolidated global surgery compensation information for all products; removed "never events" language and linked to Serious Reportable Events Payment Policy in Additional Resources; removed prior authorization information for reconstructive/cosmetic procedures and referred to medical necessity guidelines in Provider Resource Center
- September 2020: Removed reference to Claims Submission Policy (retired)
- May 2019: Added edit for photosensitive drugs and ocular photodynamic therapy, effective for dates of service on or after July 1, 2019
- June 2018: Template updates
- March 2018: Updated USFHP inclusion in NIA's Joint Surgery Program effective April 1, 2018
- November 2017: Added edits for implantable neurostimulator electrode for effective dates of service on or after January 1, 2018
- August 2017: Policy reviewed by committee; clarified global surgical compensation language
- 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
- November 2014: Added policy regarding supplies with a surgical procedure, effective for dates of service on or after January 1, 2015.
- August 2014: Policy reviewed. Minor formatting changes, moved information about unlisted procedure codes to the Claims Submission payment policy; template updates
- September 2013: Template conversion
- April 2013: Template updates

[3] The 30-day postoperative period applies to RITogether claims only, in accordance with RI EOHHS.

- May 2012: Added that effective for claims adjudicated on or after July 1, 2012, Tufts Health Plan will not compensate for an Assistant Surgeon when billed by the Primary Surgeon
- March 2012: Updated CareLink disclaimer language
- February 2012: Added link to Services Inappropriate to be Performed in an Outpatient Setting
- September 2011: Template updates; added information regarding paper Statements of Account and the Summary of Account on the secure Provider website, effective January 1, 2012
- May 2010: Added: Robotic Surgical System: Tufts Health Plan does not reimburse separately for the use of a robotic surgical system (S2900)
- November 2009: Added: Effective January 1, 2010, Tufts Health Plan will adopt CMS's differential reimbursement for office and facility-based services, replacing Tufts Health Plan's office surgery program. Refer to your contract for details regarding outpatient reimbursement provisions
- June 2009: Clarified that add-on codes will not be reimbursed if the primary procedure code has not been submitted on the same date of service
- May 2008: Added new peripheral and central venous access edit that will be effective for claims adjudicated on or after August 1, 2008
- February 2008: Added place of service reimbursement. Revised general benefit information with self-service channels information

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 a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/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.