Surgery Professional Payment Policy

The following payment policy applies to Tufts Health Plan contracted providers rendering professional surgical services in a provider office, inpatient or outpatient facility. This policy applies to Commercial¹ products (including Tufts Health Freedom Plan). 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 payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

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

POLICY
Tufts Health Plan covers medically necessary professional surgical services.

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 our secure Provider website or by contacting Provider Services.

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.

AUTHORIZATION REQUIREMENTS
Inpatient notification is required prior to services being rendered, except for urgent/emergency care. An inpatient notification does not take the place of referral or prior authorization requirements for a specific service or item. Refer to the Authorization Policy for more information.

Note: Professional claims will be denied if an inpatient notification to the hospital has not been obtained.

Providers must request prior authorization for interventional pain management, lumbar and cervical spine surgeries through National Imaging Associates (NIA). Providers can contact NIA for prior authorization through RadMD. Refer to the Spinal Conditions Management Program for more information.

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

Tufts Health Plan provides coverage of certain transgender surgical procedures when appropriate clinical criteria are met. Refer to the medical necessity guidelines for Transgender Surgical Procedures and Transgender Surgery Rider Option: Associated Procedures for more information.

Prior authorization is required for procedures that have both a cosmetic and functional component, or if it is uncertain that the procedure meets Tufts Health Plan’s definition of cosmetic and/or reconstructive. Refer to the Reconstructive and Cosmetic Surgery Medical Necessity Guidelines for additional information on coverage criteria.

COMPENSATION/REIMBURSEMENT INFORMATION
Tufts Health Plan does not routinely compensate for the following:
- Assistant surgeons when billed by the primary surgeon
- Use of a robotic surgical system (S2900)

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink™ when Tufts Health Plan is the primary administrator.
Assistant Surgeons, Co-Surgeons and Team Surgery
In alignment with CMS and the American College of Surgeons, Tufts Health Plan will consider compensation for services requiring multiple physicians 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.

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.

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

Tufts Health Plan does not routinely compensate for supplies when billed on the same date of service as a 0-, 10- or 90-day surgical procedure.

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).

Exceptions for Surgical Procedures
Certain services will 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-operative, intra-operative and post-operative services. Claims that do not have an appended modifier will be processed and compensated at the surgical rate.

Peripheral and Central Venous Access
Tufts Health Plan does not routinely compensate for a peripheral and central venous access when billed with a tunneled or nontunneled central venous access procedure. According to the National Correct Coding Policy Manual, peripheral and central venous access is considered to be an integral part of performing a tunneled or nontunneled central venous access procedure.

ADDITIONAL RESOURCES
Authorization Policy
Emergency Department Services Professional Payment Policy
DRG Inpatient Facility Payment Policy
Non-DRG Inpatient Facility Payment Policy
Claims Submission Payment Policy
Noncovered/Nonreimbursable Services Payment Policy

DOCUMENT HISTORY
- August 2017: Policy reviewed by committee; clarified global surgical compensation language
- January 2017: Template updates
- September 2015: Template updates

Revised 11/2017

Surgery Professional Payment Policy
• 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
• 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 your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s audit policies, refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction 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 guidelines when applicable, and 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 does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options, Tufts Health Public Plans or the PHCS network (also known as Multiplan). This policy applies 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.