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)
☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers rendering professional surgical services in a provider office, inpatient or outpatient facility. For information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, click here.

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 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 website or by contacting Commercial 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.

**Spinal Conditions Management and Joint Surgery**
Providers must request prior authorization for interventional pain management, lumbar and cervical spine surgeries, and joint surgeries through NIA. Providers may contact NIA for prior authorization through RadMD.

Refer to the Spinal Conditions Management Program and Joint Surgery Program for more information.

- Interventional pain management services rendered as part of ED, observation, or services rendered in a hospital inpatient setting are not subject to prior authorization
- Spinal and joint surgery services rendered as part of ED services are not subject to prior authorization
- Spinal and joint surgery procedures performed in an inpatient setting require inpatient notification from Tufts Health Plan in addition to the appropriate prior authorization for the specific procedure from NIA.

**Reconstructive and Cosmetic Procedures**
With appropriate authorization, Tufts Health Plan provides coverage for 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

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

**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 will not routinely compensate L8680 (implantable neurostimulator electrode, each) when billed with 63650 (percutaneous implantation of neurostimulator electrode array, epidural).

**Nonphysician Practitioners**

Effective for dates of service on or after July 1, 2019, Tufts Health Plan will 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.

**“Never Events”**

Tufts Health Plan does not 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 Serious Reportable Events Payment Policy for additional information on “never events.”

**Photosensitive Drugs and Ocular Photodynamic Therapy**

Effective for dates of service on or after July 1, 2019, Tufts Health Plan will 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.

**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).

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.

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 NCCI, 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
- 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
- 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.