Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Surgery Professional

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products
☒ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health One Care – A dual-eligible product

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☒ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

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.

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.

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 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 Prior Authorization Resources page.

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.

Use of labs not participating in the member's applicable network(s) may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Non-Physician Practitioners
Major surgical procedures billed by a non-physician practitioner (NPP) must have modifier 80, 81, 82 or AS appended to the claim line.

Compensation/Reimbursement Information

Providers are compensated according to the applicable network contracted rates and applicable fee schedules.

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 compensates multiple surgical procedure code(s) by paying the surgical procedure code with the Tufts Health Plan highest allowable compensation at 100 percent of the allowed amount. Subsequent surgical procedure code(s) that are subject to reduction logic are compensated at 50 percent of the allowed amount.

When a bilateral procedure code and surgical procedure code(s) are submitted together and both the bilateral and surgical procedure code(s) are eligible for multiple procedure reduction, the bilateral adjustment is applied first. The surgical procedure code(s) with the highest allowable compensation will be compensated at 100 percent after the bilateral adjustment. Other surgical procedure code(s) that are subject to reduction logic are compensated at 50 percent of the allowed amount, after bilateral adjustment, as appropriate.

Implantable Neurostimulator Electrode
L8680 (implantable neurostimulator electrode, each) is not reimbursed when billed with 63650 (percutaneous implantation of neurostimulator electrode array, epidural).

Photosensitive Drugs and Ocular Photodynamic Therapy
67221-67225 (destruction of localized lesion of choroids) is not reimbursed if billed unless J3396 (verteporfin) has been billed or paid for the same DOS.

Robotic Surgical Systems
S2900 (use of a robotic surgical system) is not separately reimbursed.

Surgical Global Day Period
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).

Global surgery includes all necessary services normally furnished by the surgeon or other qualified health care professionals before, during and after a surgical procedure. 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.

Note: The 30-day postoperative period applies to RITogether claims only, in accordance with RI EOHHS.

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.

Additional Resources

Payment Policies

- Emergency Department Services
- Evaluation and Management Professional
- Inpatient Facility
- Modifier
- Noncovered/Nonreimbursable Services
- Serious Reportable Events and Provider Preventable Conditions

Other Resources

- Noncovered Investigational Services Medical Necessity Guidelines

Document History

- September 2024: Annual policy review; added Modifier and E&M payment policies to Additional Resources; administrative updates
- November 2023: Annual review; clarified bilateral and multiple surgical procedures language
- May 2021: Added claim edits applicable to Commercial and Senior Products for minor surgery: 10-day procedures, effective for dates of service on or after July 1, 2021
- 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

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider’s network participation agreement with the Plan. 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.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and 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, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.