Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 29: Surgery Services

Effective July 1, 2024

Link: Look for possible updates and corrections to these payment policies on L&I's website.

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Certified or accredited facility or office: L&I defines a certified or accredited facility or office that has certification or accreditation from 1 of the following organizations:

- Medicare (CMS – Centers for Medicare and Medicaid Services),
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
- Accreditation Association for Ambulatory Health Care (AAAHC),
- American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF),
- American Osteopathic Association (AOA),
- Commission on Accreditation of Rehabilitation Facilities (CARF).

When services are performed in a facility setting, the insurer makes 2 payments:

- One to the professional provider, and
- One to the facility.

Payment to the facility includes resource costs, such as:

- Labor,
- Medical supplies, and
- Medical equipment.

Endoscopy: For the purpose of these payment policies, “endoscopy” will be used to refer to any invasive procedure performed with the use of a fiber optic scope or other similar instrument.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–24 (Unrelated evaluation and management (E/M) services by the same physician during a postoperative period)	
Use this modifier to indicate when an E/M service is performed during a postoperative period that was unrelated to the surgical procedure.	This modifier allows payment for the unrelated service. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same worker, on the same date of service. **Note**: This modifier should only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–50 (Bilateral surgery)	
Use this modifier to indicate when a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each side of the body the procedure was performed. Apply the modifier to the second line.	The total payment is made at **150%** of the global surgery fee schedule amount for the procedure as follows: • **100%** of the global surgery fee for the procedure on the first line. • **50%** of the global surgery fee for the procedure on the second line.

Use	Payment Information
–51 (Multiple surgeries)	
Use this modifier to indicate when multiple procedures were performed at the same operative session by the same individual. Providers must bill using separate line items for each procedure performed. Apply the modifier to all line items but the primary procedure. If the same procedure is performed on multiple levels, the provider must bill using separate line items for each level.	The total payment equals the sum of: • **100%** of the maximum allowable fee for the highest valued procedure according to the fee schedule, *plus* • **50%** of the maximum allowable fee for the subsequent procedure(s) with the next highest values according to the fee schedule.
Surgical package modifiers When providing less than the global surgical package, providers should use modifiers **–54**, **–55**, or **–56**. These modifiers are designed to ensure that the sum of all allowances for all providers doesn't exceed the total allowance for the global surgery period. These modifiers allow direct payment to the provider for each portion of the global surgery service.	
–54 (Surgical care only)	
Use this modifier to indicate when the physician performs a surgical procedure but another physician provides preoperative and/or postoperative management.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–54** column of the Professional Provider Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.

Use	Payment Information
–55 (Postoperative management only)	
Use this modifier to indicate when the physician performs the postoperative management but another physician has performed the surgical procedure.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–55** column of the Professional Provider Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.
–56 (Preoperative management only)	
Use this modifier to indicate when the physician performs the preoperative care and evaluation but another physician performs the surgical procedure.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–56** column of the Professional Provider Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.
–57 (Decision for surgery)	
Use this modifier to indicate that an Evaluation and Management (E/M) service resulted in the initial decision to perform the surgery.	This modifier doesn't affect payment but is necessary to describe the service performed.
–62 (Two surgeons)	
Use this modifier to indicate when 2 primary surgeons (usually with different specialties) performed distinct part(s) of the same procedure. Both surgeons must submit separate operative reports describing their specific roles.	Payment is made for each surgeon at **62.5%** of the global surgical fee or billed charge, whichever is less. No payment is made for an assistant in these cases.

Use	Payment Information
–66 (Team surgery)	
Use this modifier to indicate when a highly complex procedure is carried out by a surgical team. This requires the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Each surgeon must submit separate operative reports describing their specific roles.	Procedures with this modifier are reviewed and priced on an individual basis (by report).
Assistant surgeon modifiers Physicians who assist the primary physician in surgery should use modifiers **–80**, **–81**, or **–82**, depending on the medical necessity. The insurer doesn't recognize modifier **–AS**. Refer to the assistant surgeon indicator in the Professional Provider Fee Schedule to determine if assistant surgeon fees are payable. If the fee schedule indicator lists a procedure as not usually payable, justification for the necessity of an assistant surgeon must be documented in the surgeon's report to receive payment.	
–80 (Assistant surgeon)	
Use this modifier to indicate when the physician assisted on a surgery as the assistant surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.
–81 (Minimum assistant surgeon)	
Use this modifier to indicate when the physician only assisted on part of a surgery as the assistant surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.
–82 (Assistant surgeon (when qualified resident surgeon not available))	
Use this modifier to indicate when the physician assisted on a surgery when a qualified resident surgeon was not available to assist the primary surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.

Use	Payment Information
–FT (Unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit.)	
Use this modifier to indicate when a critical care E/M visit is furnished within the postoperative period but is unrelated to the surgery.	This modifier allows payment for the unrelated service. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–SU (Procedure performed in physician's office)	
This modifier isn't recognized by the insurer.	Facility fees are not payable for procedures performed in a physician's office. Services with this modifier will be **denied**.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Autologous chondrocyte implant (ACI)

Services that aren't covered

Autologous chondrocyte implants aren't covered. For details, see L&I's coverage decision.

Payment policy: Angioscopy

Payment limits

Payment for angioscopies CPT® code **35400** is limited to only 1 unit based on its complete code description encompassing multiple vessels.

Note: The work involved with varying numbers of vessels is incorporated in the RVUs.

Payment policy: Bilateral surgeries

Requirements for billing

Bilateral surgeries should be billed as 2 line items:

- Modifier **–50** must be applied to the second line item, *and*
- The second line item is paid at the lesser of the billed charge, or 50% of the fee schedule maximum.

Bilateral surgeries are considered 1 procedure when determining the highest valued procedure before applying multiple surgery rules.

Link: To see if modifier **–50** is valid with the procedure performed, check the Professional Services Fee Schedule.

Example 1: Billing for bilateral surgeries

Line item	CPT® code (and modifier)	Maximum payment (non-facility setting)	Bilateral policy applied	Allowed amount
1	**64721**	**$842.72**	—	**$842.72**(1)
2	**64721-50**	**$842.72**	**$421.36**(2)	**$421.36**
			Total allowed amount in non-facility setting:	**$1,264.08**(3)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.

(2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier **–50** is paid at 50% of the value paid for the first line item.

(3) Represents total allowable amount.

Example 2: Billing for bilateral surgeries and multiple procedures

Line item	CPT® code (and modifier)	Max payment (non-facility setting)	Bilateral policy applied	Multiple procedure policy applied	Allowed amount
1	**63042**	**$2,368.61**	—	—	**$2,368.61** (1)
2	**63042-50**	**$2,368.61**	**$1,134.31** (2)	—	**$1,134.31**
				Subtotal:	**$3,552.92** (3)
3	**22612-51**	**$2,879.64**	—	**$1,439.82**(4)	**$1,439.82**
				Total allowed amount in non-facility setting:	**$4,992.74**(5)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.

(2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier **–50** is paid at 50% of the value paid for the first line item.

(3) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.

(4) The third line item billed with modifier **–51** is paid at 50% of the maximum payment.

(5) Represents total allowable amount.

Payment policy: Bone growth stimulators

Prior authorization

These HCPCS (billing) codes for bone growth stimulators require prior authorization:

- **E0747** (Osteogenesis stimulator, electrical, noninvasive, other than spinal application), and
- **E0748** (Osteogenesis stimulator, electrical, noninvasive, spinal application), and
- **E0749** (Osteogenesis stimulator, electrical (surgically implanted)), and
- **E0760** (Osteogenesis stimulator, low intensity ultrasound, noninvasive).

The insurer, with prior authorization, pays for bone growth stimulators for specific conditions when medically necessary, including:

- Noninvasive or external stimulators including those that create a small electrical current and those that deliver a low intensity ultrasonic wave to the fracture, *and*
- Implanted electrical stimulators that supply a direct current to the bone.

Payment policy: Bone morphogenic protein (BMP)

Prior authorization

The insurer may cover the use of bone morphogenic protein 7 (rhBMP-7) as an alternative to autograft in recalcitrant long bone nonunion where use of autograft isn't feasible and alternative treatments have failed. The insurer may also cover the use of rhBMP-2 for primary anterior open or laparoscopic lumbar fusion at one level between L4 and S1, or revision lumbar fusion on a compromised injured worker for whom autologous bone and bone marrow harvest aren't feasible or not expected to result in fusion.

All of the guidelines for bone morphogenic protein treatment must be met before the insurer will authorize the procedures. In addition, lumbar fusion guidelines must be met.

Services that aren't covered

Bone morphogenic protein-2 (rhBMP-2) isn't covered for use in long bone nonunion fractures.

Bone morphogenic protein-7 (rhBMP-7) isn't covered for use in lumbar fusion.

BMP isn't covered for use in cervical spinal fusion or any other indication.

Payment policy: Closure of enterostomy

Payment limits

Closures of enterostomy **aren't payable** with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy.

CPT® code **44139** will be denied if it is billed with CPT® code **44625** or **44626**.

Payment policy: Endoscopy procedures

Endoscopy family groupings

Endoscopy procedures are grouped into clinically related families. Each **endoscopy** family contains a base procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an **endoscopy** family is listed in the Endo Base column in the Professional Services Fee Schedule.

How multiple endoscopy procedures pay

When multiple **endoscopy** procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

- The **endoscopy** procedure with the highest dollar value is 100% of the fee schedule value, *then*
- For subsequent **endoscopy** procedures, payment is the difference between the family member and the base fee (see Example 1, below), *then*
- When the maximum fee for the family member is less than the maximum base fee, the payment is $0.00 for the family member (see Example 2, below), *then*
- No additional payment is made for a base procedure when a family member is billed.

Once payment for all **endoscopy** procedures is calculated, each family is defined as an endoscopic group.

If more than 1 endoscopic group or other non-**endoscopy** procedure is billed for the same worker on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see Examples 3 and 4, below).

Multiple endoscopies that aren't related (each is a separate and unrelated procedure) are priced as follows:

- 100% of fee schedule value for each unrelated procedure, *then*
- Apply the standard multiple surgery policy.

Payment limits

Payment isn't allowed for an E/M office visit on the same day as a diagnostic or surgical endoscopic procedure unless:

- A documented, separately identifiable service is provided, and
- Modifier **–25** is used.

Example 1: Billing for 2 endoscopy procedures in the same family

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Allowed amount
Base (1)	29805	**$877.51**	**$0.00** (2)	—
1	29820	**$996.87**	**$119.36** (4)	**$119.36** (5)
2	29824	**$1,264.98**	**$11,264.98** (3)	**$1,264.98** (5)
			Total allowed amount in non-facility setting:	**$1,384.34** (6)

(1) Base code listed is reference only (not included on bill form).

(2) Payment isn't allowed for a base code when a family member is billed.

(3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(4) Allowed amount for other procedures in the same **endoscopy** family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(5) Amount allowed under the **endoscopy** policy.

(6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy doesn't apply because only 1 family of endoscopic procedures was billed.

Example 2: Billing for endoscopy family member with fee less than base procedure

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Allowed amount
Base (1)	43235	**$545.22**	—	—
1	43241	**$256.71**	**$0.00** (3)	
2	43243	**$426.46**	**$426.46** (2)	**$426.46** (4)
			Total allowed amount in non-facility setting:	**$426.46** (5)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(3) When the fee schedule maximum for a code in an **endoscopy** family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.

(4) Allowed amount under the **endoscopy** policy.

(5) Represents total allowed amount. Standard multiple surgery policy doesn't apply because only 1 endoscopic group was billed.

Example 3: Billing for 2 surgical procedures billed with an endoscopic group (highest fee)

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Standard multiple surgery policy applied
1	**11402**	**$326.29**	—	**$163.15** (5)
2	**11406**	**$597.40**	—	**$298.70** (5)
Base (1)	**29830**	**$858.91**	—	—
3	**29835**	**$956.08**	**$97.17** (3)	**$97.17** (4)
4	**29838**	**$1,114.43**	**$1,114.43** (2)	**$1,114.43**(4)
Total allowed amount in non-facility setting:				**$1.673.45** (6)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued **endoscopy** procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued **endoscopy** procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or **endoscopy** group being paid at 100% of fee schedule value.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

Example 4: Billing for 1 surgical procedure (highest fee) billed with an endoscopic group

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Standard multiple surgery policy applied
1	23412	**$1,582.27**		**$1,582.27** (4)
Base (1)	29805	**$877.51**		
2	29820	**$996.87**	**$119.36** (3)	**$59.68** (5)
3	29824	**$1,264.98**	**$1,264.98** (2)	**$632.49** (5)
Total allowed amount in non-facility setting:				**$2,274.44** (6)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued **endoscopy** procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued **endoscopy** procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or **endoscopy** group being paid at 100% of fee schedule value.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

Payment policy: Epidural adhesiolysis

Services that can be billed

Epidural adhesiolysis is covered under certain conditions. For details, see L&I's coverage decision.

Payment policy: Fractional ablative laser

Prior authorization

Fractional ablative laser fenestration of burn and traumatic scars requires prior authorization.

Services that can be billed

0479T and **0480T** are covered for fractional ablative laser fenestration of burn and traumatic scars where deemed medically necessary by the insurer to treat scarring that impairs the worker's function. Authorization will be given only for treatment of scarring that resulted from the industrial injury, or treatment thereof.

Services that aren't covered

Fractional ablative laser isn't covered for cosmetic purposes only.

Payment limits

0479T is limited to a max of 1 unit per day per claim.

0480T is limited to a max of 40 units per day per claim.

Payment policy: Global surgery

Global surgery follow up periods

Many surgeries have a follow up period during which charges for normal post-operative care are bundled into the global surgery fee.

The global surgery follow up period for each surgery is listed in the Follow Up column in the Professional Services Fee Schedule.

A new post-operative period begins with the subsequent procedure.

What is included in the follow up period

The follow up period always applies to the following CPT® codes, unless modifier **–24**, **–57** or **–FT** are appropriately used:

- E/M codes:
  - **99211**-**99215**,
  - **99231**-**99239**,
  - **99291**-**99292**,
  - **99304**-**99310**,
  - **99315**-**99316**,
  - **99347**-**99350**,
- Ophthalmological codes: **92012**-**92014**

The following services and supplies **are included** in the global surgery follow up period and are considered bundled into the surgical fee:

- The operation itself, *and*
- Pre-operative visits, in or out of the hospital, beginning on the day before the surgery, *and*
- Services by the primary surgeon, in or out of the hospital, during the post-operative period, *and*
- The following services:
  - Dressing changes, *and*
  - Local incisional care and removal of operative packs, *and*
  - Removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints, *and*

  - Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric, and rectal tubes, *and*
  - Change and removal of tracheostomy tubes, *and*
  - Cast room charges.
- Additional medical or surgical services required because of complications that don't require additional operating room procedures.

What isn't included in the follow up period

The following services and supplies aren't included in the global surgery follow up period:

- Casting materials aren't part of the global surgery policy and are paid separately, *and*
- The initial consultation or evaluation by the surgeon to determine the need for surgery, *and*
- Services of other providers except where the surgeon and the other provider(s) agree on the transfer of care, *and*
- Visits unrelated to the diagnosis of the surgical procedure performed, unless the visits occur due to surgery complications, *and*
- Treatment for the underlying condition or an added course of treatment which isn't part of the normal surgical recovery, *and*
- Diagnostic tests and procedures, including diagnostic radiological procedures, *and*
- Distinct surgical procedures during the post-operative period which aren't reoperations or treatment for complications, *and*
- Treatment for post-operative complications which requires a return trip to the operating room, *and*
- Immunotherapy management for organ transplants, *and*
- Critical care services (CPT® codes **99291** and **99292**) unrelated to the surgery where a seriously injured or burned worker is critically ill and requires constant attendance of the provider, *and*
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.

Who must perform these services to qualify for payment

The follow up period applies to any provider who participated in the surgical procedure. These providers include:

- Surgeon or physician who performed any component of the surgery (The pre, intra, and/or postoperative care of the worker; identified by modifiers **–54**, **–55**, and **–56**,),
- Assistant surgeon (identified by modifiers **–80**, **–81**, and **–82**),
- 2 surgeons (identified by modifier **–62**),
- Team surgeons (identified by modifier **–66**),
- Anesthesiologists and CRNAs.

Documentation of services

Providers (to include providers participating in multiple and team surgeries) must submit documentation in workers' individual operative reports to verify the level, type, and extent of surgical services. Surgeons using an assistant surgeon must document the name and actions of the assistant surgeon.

Payment limits

Professional inpatient services (CPT® codes **99221**-**99223**) are only payable during the follow up period if they are performed on an emergency basis.

Example: They aren't payable for scheduled hospital admissions.

Codes that are considered bundled aren't payable during the global surgery follow up period.

Supplies used during or immediately after surgery and not sent home with the worker don't meet the definition of DME and won't be reimbursed as DME.

Pneumatic compression devices used during surgery and sent home with the worker are considered surgical supplies. The cost of the device is bundled into the surgical service fee and isn't separately payable, even to DME suppliers. For details on coverage of pneumatic compression devices, see Chapter 9: Durable Medical Equipment.

Payment policy: Lumbar Intervertebral Artificial Disc Replacement

Services that aren’t covered

Lumbar intervertebral artificial disc replacements aren’t covered. For more information, see L&I’s coverage decision.

Payment policy: Meniscal allograft transplantation

Services that can be billed

Meniscal allograft transplantation is covered under certain conditions. For details, see L&I's coverage decision.

Payment policy: Microsurgery

Services that can be billed

CPT® code **69990** is an add-on surgical code that indicates an operative microscope has been used. As an add-on code, it isn't subject to multiple surgery rules.

Payment limits

CPT® code **69990** isn't payable when:

- Using magnifying loupes or other corrected vision devices, *or*
- Use of the operative microscope is an inclusive component of the procedure, (for example the procedure description specifies that microsurgical techniques are used), *or*
- Another code describes the same procedure being done with an operative microscope.

Example: CPT® code **69990** can't be billed with CPT® code **31536** because CPT® code **31536** describes the same procedure using an operating microscope.

Payment policy: Minor surgical procedures

Services that can be billed

For minor surgical procedures, the insurer only allows payment for an E/M office visit during the global period when:

- A documented, unrelated service is furnished during the post-operative period and modifier **–24** is used, or
- The provider who performs the procedure also reports a significant, separately identifiable service on the same date and modifier **–25** is used (also see Requirements for billing, below, and using CPT® billing code modifier **–25** in Chapter 10).

Services that aren't covered

Modifier **–57**, decision for surgery, isn't payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation isn't paid in addition to the procedure.

Requirements for billing

When billing with modifier **–25**, the insurer follows CPT® guidelines for the billing of an E/M service on the same day as performing a minor surgical procedure. An E/M service isn't considered a significant, separately identifiable service if the evaluation is related to the procedure. In this case, the evaluation is considered part of the preoperative and/or postoperative care and is therefore bundled into the payment for the minor surgical procedure.

However, if the evaluation is related to another condition, an E/M service may be billed.

Example: A worker is seen for a work related scalp laceration in which the provider determined sutures are needed but the worker also reports dizziness. The evaluation of the scalp laceration is considered inclusive of the preoperative service work for the laceration repair and therefore is included in the billing of the surgical code.

The evaluation of the worker's dizziness is considered a significant, separately identifiable service, and

- Modifier **–25** must be used, and
- Appropriate documentation is required describing both the minor surgical procedure and the E/M service

Payment limits

Modifier **–57** is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

Payment policy: Pre, intra, or post-operative services

Services that can be billed

The insurer will allow separate payment when different providers perform the pre-operative, intra-operative, or post-operative components of the surgery. The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule.

Requirements for billing

When different providers perform pre-operative, intra-operative, or post-operative components of the surgery, modifiers (**–54**, **–55**, or **–56**) must be used.

If different providers perform different components of the surgery (pre, intra, or post-operative care), the global surgery policy applies to each provider.

Example: If the surgeon performing the operation transfers the worker to another provider for the post-operative care, the same global surgery policy, including the restrictions in the follow up day period, applies to both providers.

Payment policy: Procedures performed in a physician's office

Services that can be billed

Procedures performed in a provider's office are paid at non-facility rates that include office expenses.

Services that aren't covered

Services billed with modifier **–SU** aren't covered.

Requirements for billing

Providers' offices must meet ASC requirements to qualify for separate facility payments.

Link: For information about these requirements, see WAC 296-23B.

Payment policy: Registered nurses as surgical assistants

Who must perform these services to qualify for payment

Licensed registered nurses may be paid to perform surgical assistant services if they submit the following documents to L&I along with their completed provider application:

- A photocopy of their valid and current registered nurse license, *and*
- A letter granting onsite hospital privileges for each institution where surgical assistant services will be performed.

Payment policy: Skin Cell Substitutes

Services that can be billed

The insurer covers certain HCPCS codes for skin cell substitutes. For the current list of covered codes, see the Professional Services Fee Schedule.

Payment policy: Standard multiple surgeries

How multiple surgeries pay

When multiple surgeries are performed on the same worker at the same operative session or on the same day, the total payment equals the sum of:

- 100% of the global fee schedule value for the procedure or procedure group with the highest value, according to the fee schedule, and
- 50% of the global fee schedule value for the second through fifth procedures with the next highest values, according to the fee schedule.

When different types of surgical procedures are performed on the worker on the same day, the payment policies will always be applied in the following sequence:

- Multiple **endoscopy** procedures, *then*
- Other modifier policies, *then*
- Standard multiple surgery policy.

Requirements for billing

All surgical procedure codes subject to the standard multiple surgery policy must be billed as a separate line item.

For additional instructions on billing bilateral procedures, see the payment policy on bilateral procedures earlier in this chapter.

Payment policy: Stem cell therapy for musculoskeletal conditions

Services that aren't covered

Stem cell therapy for musculoskeletal conditions isn't covered. For details, see L&I's coverage decision.

Payment policy: Tobacco Cessation Treatment for Surgical Care

Services that can be billed

The department has published a coverage decision for Tobacco Cessation Treatment for Surgical Care.

Requirements for billing

CPT® codes **99406** and **99407** may be billed for tobacco cessation counseling.

Billing for each claim is limited to a maximum of 8 units of any combination of the 2 codes.

Payment policy: Unlisted Surgical Procedures

General information

Some covered procedures don't have a specific code or payment level listed in the fee schedule. Thus, the provider must list the most similar procedure code or codes to the services performed including units of service in their surgical report.

Requirements for billing

When reporting such a service, the appropriate unlisted procedure code must be billed.

The insurer also requires:

- Within the surgical report, supporting documentation including a full description of the procedure or services performed and an explanation of why the services were too unusual, variable or complex to be billed using the established procedure codes. Modifiers must be included.
- The provider must also list the most similar procedure code or codes to the services performed including units of service.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for Ambulatory Surgery Center (ASC) payment	Washington Administrative Code (WAC) 296-23B
Ambulatory Surgery Center **Fee Schedule**	Fee schedules on L&I's website
Autologous chondrocyte implant (ACI)	Autologous chondrocyte implant coverage decision
Becoming an L&I Provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Bone growth stimulators	Bone growth stimulators coverage decision
Bone morphogenic protein (BMP)	Bone morphogenic protein coverage decision
Condition and Treatment Index	Condition and treatment index on L&I's website
Epidural adhesiolysis	Epidural adhesiolysis coverage decision
Medical treatment guideline for Lumbar fusion arthrodesis	Lumbar fusion arthrodesis treatment guidelines
Meniscal allograft transplantation	Meniscal allograft transplantation coverage decision
Professional Services **Fee Schedules**	Fee schedules on L&I's website
Tobacco Cessation Treatment for Surgical Care	Tobacco cessation treatment for surgical care coverage decision

Need more help?

Email L&I's Provider Hotline at PHL@Lni.wa.gov. If you would prefer a phone call, please email us your name and contact number.