

**Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims**

Chapter 29: Surgery Services

Effective July 1, 2018



Link: Look for possible **updates and corrections** to these payment policies at:

www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2018/



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Definitions

- ▶ **Certified or accredited facility or office:** L&I defines a certified or accredited facility or office that has certification or accreditation from one 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).

- ▶ **CPT® and HCPCS code modifiers mentioned in this chapter:**
 - 22 Increased Procedural Services**
Procedures with this modifier will be individually reviewed prior to payment. A report is required for this review and it must include justification for the use of the modifier explaining increased complexity required for proper treatment. Payment varies based on the report submitted.
 - 24 Unrelated evaluation and management (E/M) services by the same physician during a postoperative period**
Used to indicate an evaluation and management service unrelated to the surgical procedure was performed during a postoperative period. *Documentation must be submitted with the billing form when this modifier is used.* Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.
 - 25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure**
Payment is made at 100% of the fee schedule level or billed charge, whichever is less.
 - 26 Professional component**
Certain procedures are a combination of the professional (**–26**) and technical (**–TC**) components. This modifier should be used when only the professional component is performed. When a global service is performed, neither the **–26** nor the **–TC** modifier should be used. (See above for information on the use of the **–TC** modifier.)
 - 50 Bilateral surgery**
The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. Payment is made at one hundred fifty percent of the global surgery fee for the procedure. Providers must

bill using two line items on the bill form. The modifier –50 should be applied to the second line item.

–51 Multiple surgeries

For procedure codes that represent multiple surgical procedures, payment is made based on the fee schedule allowance associated with that code. Refer to the global surgery rules for additional information.

–54 Surgical care only (see Note, below)

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management.

–55 Postoperative management only (see Note, below)

When one physician performs the postoperative management and another physician has performed the surgical procedure.

–56 Preoperative management only (see Note, below)

When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure.



Note: When providing less than the global surgical package, providers should use modifiers –54, –55, and –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 of each portion of the global surgery services.

–57 Decision for surgery

Used only when the decision for surgery was made during the preoperative period of a surgical procedure with a global surgery follow up period. It shouldn't be used with visits furnished during the global period of minor procedures (0-10 day global period) unless the purpose of the visit is a decision for major surgery. Separate payment should be made even if the visit falls within the global surgery period. No separate documentation is needed when submitting a billing form with this modifier.

–58 Staged or related procedure or service by the same physician during the postoperative period

Used to report a surgical procedure that is staged or related to the primary surgical procedure and is performed during the global period.

–62 Two surgeons

For surgery requiring the skills of two surgeons (usually with a different specialty), each surgeon is paid at 62.5% of the global surgical fee. No payment is made for an

assistant-at-surgery in these cases. Both surgeons must submit separate operative reports describing their specific roles.

–66 Team surgery

Used when highly complex procedures are carried out by a surgical team. This may include the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. Each surgeon must submit separate operative reports describing their specific roles.

–78 Return to the operating room for a related procedure during the postoperative period

Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

–79 Unrelated procedure or service by the same physician during the postoperative period

Use of this modifier allows separate payment for procedures not associated with the original surgery. Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

–80 Assistant surgeon (see below)

–81 Minimum assistant surgeon (see below)

–82 Assistant surgeon (when qualified resident surgeon not available)

Assistant surgeon modifiers. Physicians who assist the primary physician in surgery should use **modifiers –80, –81, or –82** depending on the medical necessity. Payment for procedures with these modifiers is made at the billed charge or twenty percent of the global surgery amount for the procedure, whichever is less. Refer to the assistant surgeon indicator in the Professional Services Fee Schedule to determine if assistant surgeon fees are payable. If fee schedule indicator lists a procedure as not usually payable, justification for the necessity of an assistant surgeon must be documented in your report to receive payment.

–SU Procedure performed in physician's office

Denotes the use of facility and equipment while performing a procedure in a provider's office.

–TC Technical component

Certain procedures are a combination of the professional (**–26**) and technical (**–TC**) components. This modifier should be used when only the technical component is performed. When a global service is performed, neither the **–26** nor the **–TC** modifier should be used. (See above for information on the use of the **–26** modifier.)

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



Payment policy: Autologous chondrocyte implant (ACI)

▶ Services not covered

Autologous chondrocyte implants are not covered.



Link: For more information, go to:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/autologouschondrocyteimplant.asp



Payment policy: Angioscopy

▶ Payment limits

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



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



Payment policy: Bilateral surgeries

► Requirements for billing

Bilateral surgeries should be billed as two 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 one 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 at:

<http://feeschedules.Lni.wa.gov>

► Example 1: Billing for bilateral surgeries

Line item	CPT® code (and modifier)	Maximum payment (non-facility setting)	Bilateral policy applied	Allowed amount
1	64721	\$816.37	—	\$816.37 ⁽¹⁾
2	64721-50	\$816.37	\$408.19 ⁽²⁾	\$408.19
Total allowed amount in non-facility setting:				\$1,224.56⁽³⁾

- (1) Allowed amount for the highest valued procedure is the fee schedule maximum.
- (2) When applying the bilateral payment policy, the two line items will be treated as one 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	\$2,459.47	—	—	\$2,459.47 ⁽¹⁾
2	63042-50	\$2,459.47	\$1,229.74 ⁽²⁾	—	\$1,229.74
<i>Subtotal:</i>					\$3,689.21 ⁽³⁾
3	22612-51	\$3,010.41	—	\$1,505.21 ⁽⁴⁾	\$1,505.21
Total allowed amount in non-facility setting:					\$5,194.42 ⁽⁵⁾

- (1) Allowed amount for the highest valued procedure is the fee schedule maximum.
- (2) When applying the bilateral payment policy, the two line items will be treated as one 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 proper and 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.



Link: For more information, go to:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonegrowthstimulators.asp



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 patient for whom autologous bone and bone marrow harvest are not feasible or not expected to result in fusion.



Note:

- 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.

All of the criteria and guidelines must be met before the insurer will authorize the procedures.



Link: For more information, go to:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonemorphogenics.asp

In addition, lumbar fusion guidelines must be met.



Link: For more information, go to:

<http://www.Lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/LumbarFusion.pdf>

▶ Requirements for billing

CPT® codes used depend on the specific procedure being performed.



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

(See definition of **endoscopy** in Definitions at the beginning of this chapter.)

► 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.



Link: For more information, go to the Professional Services Fee Schedule at: <http://feeschedules.Lni.wa.gov>



Link: To determine the endobase procedure, please reference the “Endo” column in the [complete 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 one endoscopic group or other non-endoscopy procedure is billed for the same patient 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% 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 two endoscopy procedures in the same family

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Allowed amount
Base ⁽¹⁾	29805	\$896.00	\$0.00 ⁽²⁾	—
1	29820	\$1,013.83	\$117.83 ⁽⁴⁾	\$117.83 ⁽⁵⁾
2	29824	\$1,266.31	\$1,266.31 ⁽³⁾	\$1,266.31 ⁽⁵⁾
Total allowed amount in non-facility setting:				\$1,384.14 ⁽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 one 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	\$488.79	—	—
1	43241	\$273.85	\$0.00 ⁽³⁾	
2	43243	\$456.42	\$456.42 ⁽²⁾	\$456.42 ⁽⁴⁾
Total allowed amount in non-facility setting:				\$456.42 ⁽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 two 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	\$317.87	—	\$158.94 ⁽⁵⁾
2	11406	\$594.96	—	\$297.48 ⁽⁵⁾
Base ⁽¹⁾	29830	\$866.87	—	—
3	29835	\$965.27	\$98.40 ⁽³⁾	\$98.40 ⁽⁴⁾
4	29838	\$1,116.77	\$1,116.77 ⁽²⁾	\$1,116.77 ⁽⁴⁾
Total allowed amount in non-facility setting:				\$1,671.59⁽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%.
- (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 one 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	\$1,613.32		\$1,613.32 ⁽⁴⁾
Base ⁽¹⁾	29805	\$896.00		
2	29820	\$1,013.83	\$117.83 ⁽³⁾	\$ 58.91 ⁽⁵⁾
3	29824	\$1,266.31	\$1,266.31 ⁽²⁾	\$ 633.16 ⁽⁵⁾
Total allowed amount in non-facility setting:				\$2,305.39⁽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%.
- (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

The department has published a coverage decision about epidural adhesiolysis.



Link: For more information, go to:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Epiduraladhesiolysis.asp



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.

▶ What is included in the follow up period

The follow up period always applies to the following CPT® codes, unless **modifier –22, –24, –25, –57, –58, –78, or –79** is appropriately used:

- **E/M codes:**

- 99211-99215, *and*
- 99218-99220, *and*
- 99231-99239, *and*
- 99291-99292, *and*
- 99304-99310, *and*
- 99315-99318, *and*
- 99334-99337, *and*
- 99347-99350, *and*

- **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*



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

- 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 patient 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 patient; identified by **modifiers –56, –54, and –55**), *and*
- Assistant surgeon (identified by **modifiers –80, –81, and –82**), *and*
- Two surgeons (identified by **modifier –62**), *and*
- Team surgeons (identified by **modifier –66**), *and*
- Anesthesiologists and CRNAs.



Note: Documentation of services: All 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.

▶ 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.



Payment policy: Lumbar Intervertebral Artificial Disc Replacement

▶ Services not covered

Lumbar intervertebral artificial disc replacements are **not covered**.



Link: For more information, go to:

[www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/LumbarADR.
asp](http://www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/LumbarADR.asp)



Payment policy: Meniscal allograft transplantation

The department has published a coverage decision about meniscal allograft transplantation.



Link: For more information, go to:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/CovMedDev/SpecCovDec/Meniscal.asp



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 **31535** because CPT® code **31536** describes the same procedure using an operating microscope. (See below for a complete list of all such codes.)

These CPT® codes aren't allowed with CPT® **69990**:

- **15756-15758**, *or*
- **15842**, *or*
- **19364**, *or*
- **19368**, *or*
- **20955-20962**, *or*
- **20969-20973**, *or*
- **22551**, *or*
- **22552**, *or*
- **22856-22861**, *or*
- **26551-26554**, *or*
- **26556**, *or*

- 31526, *or*
- 31531, *or*
- 31536, *or*
- 31541-31546, *or*
- 31561, *or*
- 31571, *or*
- 43116, *or*
- 43180, *or*
- 43496, *or*
- 46601, *or*
- 46607, *or*
- 49906, *or*
- 61548, *or*
- 63075-63078, *or*
- 64727, *or*
- 64820-64823, *or*
- 65091-68850, *or*
- 0184T, *or*
- 0308T.



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 is seeing the patient for the first time an initial new patient E/M service can be billed (also see Requirements for billing, below).

▶ 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.



Note: Also see Payment limits, below.

▶ Requirements for billing

When the provider who performed the minor surgical procedure is seeing the patient for the first time **bills an initial new patient E/M service**:

- This is considered a significant, separately identifiable service, *and*
- **Modifier –25** must be used, *and*
- Appropriate documentation must be made in the chart describing 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.



Note: Also see Services that aren't covered, above.



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.



Note: Also see Requirements for billing, below.



Link: The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule, available at: <http://feeschedules.Lni.wa.gov>

▶ 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.



Note: Also see Services that can be billed, above.

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 patient 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.



Note: Also see the Global surgery payment policy earlier in this chapter.



Payment policy: Procedures performed in a physician's office

▶ Services that are covered

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 her/his 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: Standard multiple surgeries

▶ How multiple surgeries pay

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

- **100%** of the global fee for the procedure or procedure group with the highest value, according to the fee schedule, *and*
- **50%** of the global fee 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 patient 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

More than five surgical procedures performed on the same patient on the same day require documentation and individual review to determine payment amount.

When the same surgical procedure is performed on multiple levels, each level must be billed as a separate line item.



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



Payment policy: Tobacco Cessation Treatment for Surgical Care

▶ Insurer Policy

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 eight units of any combination of the two codes.



Link: For information about these requirements, see

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/TobaccoCessation.asp.



Links: Related topics

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Ambulatory Surgery Center Fee Schedule	L&I's website: http://feeschedules.Lni.wa.gov
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Becoming an L&I Provider	L&I's website: http://www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Bone growth stimulators	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonegrowthstimulators.asp
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<p>Professional Services Fee Schedules</p>	<p>L&I's website: http://feeschedules.Lni.wa.gov</p>
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