CLINICAL PAYMENT AND CODING POLICY

If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Surgical and Non-Surgical Services Guide

Policy Number: TXCPCP03

Version 1.0

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Description

The purpose of this policy is to define surgical services and provide guidance on what is considered a non-surgical service.

The American Medical Association adopted the definition of surgery from the American College of Surgeons. **Surgery is defined as** "Performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes and needles.

The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular and intravenous when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel."

Non-Surgical Services

Non-surgical services are those which diagnose, measure or treat problems for disease or injury that do not require surgery. These services are non-invasive and therefore would not require an incision into the body or the removal of tissue. The following is not an all-inclusive list but are examples of non-surgical/non-invasive services or procedures:

- Tests, x-rays and/or scans
- Cosmetic procedures that are non-surgical (e.g., facial peels, body contouring, injections)
- Physical examinations
- Rehabilitative procedures or allied health therapies that help restore a person's physical function
- Therapy treatments such as radiation therapies, physical therapies or the use of medications (e.g., trigger point injections)
- Evaluation and Management (E/M) services

Reimbursement Information:

- Providers must append the appropriate modifier to supervising physician claim submissions when billing on behalf of a mid-level provider or other qualified surgical assistants for surgical and non-surgical services. For more information on appropriate modifiers, see **CPCP023 Modifier Reference Guideline**.
- Supplies used for non-surgical services are not reimbursed separately unless otherwise specified.
- CPT codes listed in the Surgery section of the CPT book (10004-69990) and additional related HCPCS codes (e.g., some HCPCS Level II G codes) are surgical procedure codes. Non-surgical services, such as lab tests, radiology procedures, evaluation and management services, etc., that are billed with surgical codes must be submitted with per date of service documentation.
- If surgical procedure codes are billed during a global day indicator of 0, 10, 90, YYY or ZZZ, documentation must support billing services during the global period. For more information, see **CPCP014 Global Surgical Package-Professional Providers**.

The plan reserves the right to request supporting documentation. Claim(s) that do not adhere to coding and billing guidelines may result in a denial or reassigned payment rate. Claims may be reviewed on a case-by-case basis. For additional information related to this policy, please refer to the Plan's website or contact your Network Management Office.

References:

AMA Policy Finder- Surgery

CPCP014 Global Surgical Package-Professional Providers

CPCP023 Modifier Reference Guideline

Policy Update History:

3/25/2021	New policy