Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter PHY-131
March 2011

TO: Physicians Participating in MassHealth

FROM: Terence G. Dougherty, Medicaid Director

RE: *Physician Manual* (Amendments to Regulations about Payment for Surgery Services)

MassHealth has revised its regulations related to payment for multiple surgeries performed on the same day and has developed new rules for global surgery periods.

Under the new policy, payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. The services included within the global surgical package are not payable separately, regardless of the setting in which those services were performed.

In addition to a description of the global surgical package, the provisions in 130 CMR 433.451 and 433.452 describe payment for multiple surgeries and endoscopies, add-on surgical procedures, bilateral procedures, surgical assistants, team surgery, and co-surgery (two surgeons). The modifiers MassHealth has adopted are listed in Section 605 of Subchapter 6 of the MassHealth *Physician Manual*.

These amendments are effective for dates of service on or after **April 1, 2011**.

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Physician Manual

Pages iv-a, 4-41, 4-42, 4-42a, 4-42b, 4-43, and 4-44

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Physician Manual

Page iv-a — transmitted by Transmittal Letter PHY-124

Pages 4-41 through 4-44 — transmitted by Transmittal Letter PHY-123

4. Program Regulations (cont.)

433.449: Fluoride Varnish Services

(A) Eligible Members. Members must be under the age of 21 to be eligible for the application of fluoride varnish.

(B) Qualified Providers. Physicians, nurse practitioners, registered nurses, licensed practical nurses, and physician assistants may apply fluoride varnish subject to the limitations of state law. Providers must complete a MassHealth-approved training on the application of fluoride varnish, maintain proof of completion of the training, and provide such proof to the MassHealth agency upon request.

(C) Billing for an Office Visit and Fluoride Varnish Treatment/Procedure. A physician may bill for fluoride varnish services provided by the physician or a qualified staff member as listed in 130 CMR 433.449(B) under the supervision of a physician. The physician may bill for an office visit, in addition to the fluoride varnish application, only if fluoride varnish was not the sole service, treatment, or procedure provided during the visit.

(D) Claims Submission. Physicians and independent nurse practitioners may submit claims for fluoride varnish services when they provide those services directly to MassHealth members. These are the only MassHealth provider types who may bill for this service independently under these regulations. A physician may also submit claims for fluoride varnish services that are provided by nurse practitioners, registered nurses, licensed practical nurses, and physician assistants according to 130 CMR 433.449(C). See Subchapter 6 of the *Physician Manual* for service codes and descriptions.

(130 CMR 433.450 Reserved)

Part 3. Surgery Services

433.451: Surgery Services: Introduction

(A) Provider Eligibility. The MassHealth agency pays a physician for surgery only if the physician is scrubbed and present in the operating room during the major portion of the operation. (See 130 CMR 433.421(D)(1) for the single exception to this requirement.)

(B) Nonpayable Services. The MassHealth agency does not pay for
(1) any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment. This specifically includes, but is not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, and any other related surgeries;
(2) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment);
(3) reconstructive surgery, unless the MassHealth agency determines, pursuant to a request for prior authorization, the service is medically necessary to correct, repair, or ameliorate the physical effects of physical disease or defect, or traumatic injury;
(4) services billed under codes listed in Subchapter 6 of the *Physician Manual* as not payable;
(5) services otherwise identified in MassHealth regulations at 130 CMR 433.000 or 450.000 as not payable; and
(6) services billed with otherwise covered service codes when such codes are used to bill for nonpayable circumstances as described in 130 CMR 433.404.

(C) Definitions. The following terms have the meanings given for purposes of 130 CMR 433.451 and 433.452, unless otherwise indicated.

(1) Complications Following Surgery – all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications that do not require additional trips to the operating room.

(2) Evaluation and Management (E/M) Services – visits and consultations furnished by physicians in various settings and of various complexities as defined in the Evaluation and Management section of the American Medical Association's *Current Procedural Terminology (CPT)* code book.

(3) Intraoperative Services – intraoperative services that are normally a usual and necessary part of a surgical procedure.

(4) Major Surgery – a surgery for which the Centers for Medicare & Medicaid Services (CMS) determines the preoperative period is one day and the postoperative period is 90 days.

(5) Minor Surgery – a surgery for which CMS determines the preoperative period is zero days and the postoperative period is zero or 10 days.

(6) Postoperative Period –

(a) The postoperative period for major surgery is 90 days.

(b) The postoperative period for minor surgery and endoscopies is zero or 10 days.

(7) Postoperative Visits – follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery.

(8) Postsurgical Pain Management – postsurgical pain management by the surgeon, including supplies.

(9) Preoperative Period –

(a) The preoperative period for major surgery is one day.

(b) The preoperative period for minor surgery is zero days.

(10) Preoperative Visits – preoperative visits after the decision is made to operate, beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures.

433.452: Surgery Services: Payment

Surgical services and other invasive procedures are listed in the surgery and medicine section of the American Medical Association's *Current Procedural Terminology (CPT)* code book. The MassHealth agency pays for all medicine and surgery CPT codes in effect at the time of service, except for those codes listed in Section 602 of Subchapter 6 of the *Physician Manual*, subject to all conditions and limitations described in MassHealth regulations at 130 CMR 433.000 and 450.000.

(A) Visit and Treatment/Procedure on Same Day in Same Location. The MassHealth agency pays a physician for either a visit or a treatment/procedure, whichever fee is greater. The MassHealth agency does not pay for both a preoperative evaluation and management visit, and a treatment/procedure provided to a member on the same day when they are performed in the same location. For minor surgeries and endoscopies, the MassHealth agency does not pay separately for an evaluation and management service on the same day as the surgery or endoscopy. For payment information about obstetrical care, refer to 130 CMR 433.421.

(B) Payment for Global Surgical Package. The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. The services are included in the global surgical package regardless of setting, including but not limited to hospitals, ambulatory surgical centers, and physicians' offices.

(1) The following services are included in the payment for a global surgery when furnished by the physician who performs the surgery:

(a) preoperative visits;
(b) intraoperative visits;
(c) complications following surgery;
(d) postoperative visits;
(e) postsurgical pain management;
(f) miscellaneous services related to surgery, including but not limited to dressing changes; local incisional care; removal of operative pack, cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes; and changes and removal of tracheostomy tubes; and
(g) visits related to the surgery to a patient in an intensive care or critical care unit, if made by the surgeon. Intensive or critical care visits unrelated to surgery are not included in the global surgical package.

(2) The following services are not included in the payment for a global surgery:

(a) the initial consultation or evaluation of the problem by the surgeon to determine the need for surgery;
(b) services of other physicians except where the surgeon and the other physician or physicians agree on the transfer of care during the global period. Such transfer agreement must be in writing and a copy of the written transfer agreement must be kept in the member's medical record;
(c) visits unrelated to the diagnosis for which the surgical procedure is performed;
(d) treatment for the underlying condition or an added course of treatment that is not part of the normal recovery from the surgery;
(e) diagnostic tests and procedures, including diagnostic radiological procedures;
(f) clearly distinct surgical procedures during the postoperative period that are not reoperations or treatment for complications resulting from the surgery. A new postoperative period begins with the subsequent surgical procedure. This exception includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure;
(g) treatment for postoperative complications that require a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical that there would be insufficient time for transportation to an OR);
(h) a second, more extensive procedure required because the initial, less extensive procedure did not produce the desired outcome;
(i) immunotherapy management for organ transplants; and
(j) critical care services unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance by the physician.

(C) Payment for Multiple Surgeries. Multiple surgeries are separate procedures performed by a physician on the same patient at the same operative session or on the same day. Multiple surgeries are distinguished from intraoperative services and surgeries that are incidental to or components of a primary surgery (that is, bundled services). Bundled services are not paid separately. When two or more related procedures are performed on a patient during a single session or visit, the MassHealth agency pays the provider for the comprehensive code and denies or adjusts the component, incidental, or mutually exclusive procedure performed during the same session. The bundling guidelines that MassHealth applies are based upon generally accepted industry guidelines including, but not limited to the Correct Coding Initiative administered through the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association's *Current Procedural Terminology (CPT)* code book. To receive payment for multiple surgeries, the surgeon must bill with the multiple surgery modifier.

(D) Payment for Multiple Endoscopy Procedures. When multiple procedures are performed through the same endoscope, payment is made for the highest valued endoscopy procedure plus the difference between the next highest endoscopy procedure and the base endoscopy procedure. The base endoscopy procedure is included in the code for each of the multiple procedures. When two related endoscopies and an unrelated endoscopy are performed, the endoscopic payment rule stated above applies to the related endoscopies. Unrelated endoscopic procedures are treated as separate surgeries and paid as multiple surgeries pursuant to 130 CMR 433.452(C).

(E) Payment for Add-on Surgical Procedures. The Centers for Medicare & Medicaid Services (CMS) has identified certain procedures as add-on procedures that are always billed with another procedure. Add-on codes are identified in the CPT code book. By definition, these services do not stand alone and must be provided in conjunction with a primary surgical procedure or qualifying service. Both the service code for the primary procedure and add-on code are paid separately. The global surgery package provisions at 130 CMR 455.451 and 455.452 apply to the service code for the primary procedure.

(F) Payment for Bilateral Procedures. Bilateral surgeries are defined as procedures performed on both sides of the body during the same operative session or on the same day. To receive payment, the surgeon must use the bilateral surgery modifier with the appropriate service code. The provider must not use the bilateral surgery modifier with service codes containing the terms "bilateral" or "unilateral or bilateral" in their definitions, since the terminology of the code identifies the service as one whose payment accounts for any additional work required for bilateral surgery.

(G) Surgical Assistants. Some surgical procedures require a primary surgeon and an assistant surgeon. To receive payment, the assistant surgeon must use the appropriate modifier. Surgical codes that accept the surgical assistant modifiers are indicated in The Centers for Medicare & Medicaid Services *Correct Coding Initiative Guide*. In addition, the MassHealth agency does not pay for a surgical assistant if

(1) any component of the surgery is billed using a team surgery modifier pursuant to 130 CMR 433.452(H) or a two-surgeon modifier pursuant to 130 CMR 433.452(I);

(2) the surgery services were provided in a teaching hospital that has an approved training program related to the medical specialty required for the surgical procedure and a qualified resident available to perform the services. If no qualified resident is available to perform the services, the MassHealth agency pays for a surgical assistant if the member's medical record documents that a qualified resident was unavailable at the time of the surgery; or

(3) the surgical procedure does not require the services of more than one surgeon.

(H) Team Surgery. Under some circumstances, the MassHealth agency pays for highly complex surgical procedures requiring the concomitant services of more than two surgeons as "team surgery." The MassHealth agency pays a single consolidated payment for team surgery to the director of the surgical team. To receive payment, the director of the team must use the team surgery modifier. Payment includes all surgical assistant fees. The director of the surgical team is expected to distribute the MassHealth payment to the other physician members of the surgical team.

(I) Two Surgeons (Co-Surgery). The MassHealth agency pays for co-surgery when two surgeons work together as primary surgeons performing distinct parts of a reportable procedure. To receive payment, each surgeon must use the two surgeons modifier. Payment includes all surgical assistant fees.

(130 CMR 433.453 Reserved)

433.454: Anesthesia Services

(A) Payment.

(1) Payment Determination. Payment for anesthesia services is determined using base anesthesia units and time units. To determine payment, the MassHealth agency multiplies the anesthesia unit fee established by DHCFP by the time units reported on the claim pursuant to 130 CMR 433.454(A)(2)(c), plus the number of base units, if any have been set by DHCFP. The number of base units is the same for a surgical procedure, regardless of the type of anesthesia administered, including acupuncture (see 130 CMR 433.454(C)).

(2) Calculation.

(a) Anesthesia Units. The MassHealth agency pays for anesthesia services by multiplying the time units plus any base anesthesia units by the unit fee established by DHCFP. If DHCFP has not established base anesthesia units for a service, the MassHealth agency pays using time units only.

(b) Determining Payable Anesthesia Time. Payable anesthesia time starts when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or equivalent area. Payable anesthesia time ends when the patient may be safely placed under postoperative supervision.

(c) Reporting Time Units. A provider's claim must report only payable time units. It must not include base anesthesia units or units that exceed the criteria described in 130 CMR 433.454(A)(2)(b) in the number of units field on the claim. To calculate the correct number of time units, the provider must determine the number of 15-minute intervals of payable anesthesia time plus any remaining fraction, provided such fraction equals or exceeds five minutes.

(3) Multiple Surgery Procedures. When anesthesia is administered for multiple surgery procedures, the MassHealth agency applies only the base anesthesia units for the procedure with the largest number of units to determine the maximum allowable fee.

(B) Services Provided by a Nurse-Anesthetist.

(1) Anesthesia services provided by a nurse-anesthetist are payable only if the nurse-anesthetist

(a) is authorized by law to perform the services;

(b) is a full-time employee of the physician and is not a salaried employee of the hospital; and

(c) performs the services under the direct and continuous supervision of the physician.

(2) The supervising physician must be in the operating suite and responsible for no more than four operating rooms. Availability of the physician by telephone does not constitute direct and continuous supervision.

(C) Acupuncture as an Anesthetic. The MassHealth agency pays for acupuncture only as a substitute for conventional surgical anesthesia.