Procedure Codes Assigned to Surgical Benefit Categories

Last Updated: 2/12/2025 **Last Reviewed: 2/12/2025** **Originally Effective: 1/1/2000**

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM023**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** All

Reimbursement Guidelines

A. General

Procedure codes are assigned to a surgical benefit category based on the nature of the procedure and when Medicare (CMS) considers the code to be a surgical procedure based on the various indicators on the physician fee schedule.

B. Types of Surgical Benefit Categories

Surgical benefit categories include both general surgical procedures and certain specific surgery benefit categories, including but not limited to:

- Endoscopic surgery
- Infertility surgery
- Family Planning surgery
- Maternity surgery
- Medicare Routine Foot Care
- Transplant surgery

C. Nature of the Procedure

Surgical procedures do not always require general anesthesia, an operating room, a skin incision, or sutures to be considered a surgical procedure. Surgical procedures include but are not limited to the following:

- Incision
- Excision
- Amputation
- Introduction (of needles, catheters, or instruments, etc.)
- Endoscopy
- Repair
- Destruction (e.g., warts, lesions, abnormal tissue, etc.)
- Sutures
- Manipulation
  - Treatment of fractures
  - Treatment of dislocations
- Treatment of burns

D. Medicare (CMS) Indicators of Surgical Procedures

1. Global Surgery Days Indicator.
   a. All procedure codes with a global days indicator of “10” and “90” on the Medicare (CMS) physician fee schedule are considered a surgical procedure code.
   b. Procedure codes with a global days indicator of “0” days:
      i. Most are considered a surgical procedure code.

ii. Some are not considered a surgical procedure code, depending upon the nature of the service described.

c. Global days indicator of "MMM" are considered maternity services. Specific Maternity procedures (cesarean delivery, Ligation or transection of fallopian tube(s), hysterectomy after cesarean delivery, etc.) are also considered Maternity surgical codes.

d. Procedure codes with a global days indicator of "XXX," "YYY," and "ZZZ" may be considered a surgical procedure code, depending upon the nature of the service described.
Contributing factors to help clarify the nature of the service include:
   i. Key words in the procedure code description.
   ii. Methods used to perform the procedure.
   iii. Other indicators on the physician fee schedule.

2. When a determination needs to be made whether a new procedure code is or is not a surgical procedure before the CMS indicator information is available (global surgery days and others), the procedure code description wording itself is used to make the determination.

E. Locations and Settings

Depending upon the nature and extent of the service, a surgical procedure may be performed in a wide variety of settings, including:

- Physician's office
- Patient room or bedside
- Emergency department
- Cath lab
- Interventional radiology procedure room
- Endoscopy room
- Operating room

F. Specific Examples

The following types of procedures may not initially appear to be surgical procedures but are assigned to a surgical benefit category. This list is not intended to be comprehensive to address every type of question which may arise.

Closed Treatment of Fractures or Dislocated Joints

Some fractures and joint dislocations can be treated with x-ray assessment, ensuring proper alignment of the bones and/or joint, and stabilization and immobilization with a cast or splint. Procedure codes for closed treatment of a fractured bone, with or without manipulation, and treatment of a closed joint dislocation, with or without anesthesia, are listed in the surgical section of the CPT book and are assigned global surgery package days on the CMS Physician Fee Schedule.

Application of Casts and Strapping

Procedure codes for the application of casts and/or strapping are listed in the surgical section of the CPT book and are assigned global surgery package days of 000 on the CMS Physician Fee Schedule.
(Note: Specific coding and bundling rules are listed in the CPT book and/or the CPT Assistant as to when these procedures may and may not be separately reported and/or reimbursed.)

Endoscopy procedures

An endoscopy is the examination and treatment of the inside of the body by using a lighted, flexible instrument called an endoscope. In general, an endoscope is introduced into the body through a natural opening such as the mouth or anus. Although endoscopy can include examination of other organs, the most common endoscopic procedures evaluate the nose, sinuses, esophagus, stomach, and portions of

the intestine. Tools for cutting, grasping, cautery, balloon dilation, or other tools may be attached or passed through the endoscope instrument.

Endoscopy procedures are considered surgical procedures. Endoscopy procedure codes are listed in the surgical section of the CPT book or HCPCS codes and are assigned global surgery package days on the CMS Physician Fee Schedule.

Cardiac catheterization and cardiac electrophysiology procedures

Cardiac catheterization and electrophysiology procedures access the heart for examination and/or treatment by passing a small tube through the skin into a blood vessel (usually in the groin or neck) and through the blood vessels to the heart. These procedures usually take place in a special radiology procedure room (e.g., cath lab) using light sedation.

Cardiac catheterization and electrophysiology procedure codes are in the Medicine section of the CPT book but are designated as surgical procedures by Medicare.

Needle biopsies and other percutaneous needle procedures

A number of procedures access organs, muscles, tissues, or joints with a needle inserted through the skin. This includes needle biopsies, trigger point injections, aspiration of fluid from a joint, or injection of substances into the joint, etc. These are considered surgical procedures by the AMA and/or Medicare, and the procedure codes are generally (but not always) listed in the surgical section of the CPT book.

Removal of warts, skin tags, etc.

Warts, skin tags, actinic keratosis lesions, and other benign lesions can be removed by a variety of means, such as laser, electrosurgery, cryosurgery (application of cold, liquid nitrogen, “freezing”), application of other chemicals, etc. These procedures are considered surgical procedures, are listed in the surgical section of the CPT book and are assigned global surgery package days on the CMS Physician Fee Schedule.

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
CCI	Correct Coding Initiative (see “NCCI”)
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DRG	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	National Correct Coding Initiative (aka “CCI”)
RPM	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
UB	Uniform Bill

CMS Global Days (period) Indicators Currently in Use

Global Days Indicator	Indicator Definition
000	Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.
010	Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.
090	Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.
MMM	Maternity codes; usual global period does not apply.
XXX	Global concept does not apply.
YYY	Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.
ZZZ	Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post service time.)

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Global Surgery Package for Professional Claims." Moda Health Reimbursement Policy Manual, RPM011.
C. "Modifier 51 - Multiple Procedure Fee Reductions." Moda Health Reimbursement Policy Manual, RPM022.
D. "Modifiers 58, 78, and 79 – Staged, Related, and Unrelated Procedures." Moda Health Reimbursement Policy Manual, RPM010.
E. "Modifiers 54, 55, and 56 – Split Surgical Care." Moda Health Reimbursement Policy Manual, RPM030.

Resources

1. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, Addendum - MPFSDB Record Layouts.
2. "Definition of Endoscopy." *MedicineNet.com*. (Owned and operated by WebMD). Accessed April 9, 2013; http://www.medterms.com/script/main/art.asp?articlekey=12538.Item 3. Etcetera.

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
2/12/2025	Related Policies updated. Formatting updates. No policy changes.
2/14/2024	Formatting updates. No policy changes.
10/12/2022	Clarified CMS Physician Fee Schedule is source of specific global period days settings. Scope updated to include Idaho. Related Policies updated. No policy changes. Formatting updates. Policy History entries prior to 2022 omitted (in archive storage).

Date	Summary of Update
5/8/2013	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
Prior to 1/1/2000	Original Effective Date (with or without formal documentation). Policy based on the nature of the procedure and various CMS Physician Fee Schedule status indicators.