

SURGERY

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I. APPLICABILITY

Paragraphs III.A. through G. apply to reimbursement of services provided by network and non-network providers. Paragraphs III.H. and I. apply only to non-network providers.

II. ISSUE

How is surgery to be reimbursed?

III. POLICY

A. Multiple Surgery and Discounting Reimbursement.

1. The following rules are to be followed whenever there is a terminated procedure or more than one surgical procedure performed during the same operative or outpatient session. This applies to those facilities that are exempt from the hospital Outpatient Prospective Payment System (OPPS) and for claims submitted by individual professional providers for services rendered on or after **May 1, 2009** (implementation of OPPS):

a. Discounting for Multiple Procedures.

(1) When more than one surgical procedure code subject to discounting (see [Chapter 13, Section 3](#)) is performed during a single operative or outpatient session, TRICARE will reimburse the full payment and the beneficiary will pay the cost-share/copayment for the procedure having the highest payment rate.

(2) Fifty percent (50%) of the usual payment amount and beneficiary copayment/cost-share amount will be paid for all other procedures subject to discounting (see [Chapter 13, Section 3](#)) performed during the same operative or outpatient session to reflect the savings associated with having to prepare the patient only once and the incremental costs associated with anesthesia, operating and recovery room use, and other services required for the second and subsequent procedures.

(a) The reduced payment would apply only to the surgical procedure with the lower payment rate.

(b) The reduced payment for multiple procedures would apply to both the beneficiary copayment/cost-share and the TRICARE payment.

NOTE: Certain codes are considered an add-on or modifier 51 exempt procedure for non-OPPS professional and facility claims, which should not apply a reduction as a secondary procedure. These codes should not be subject to OPPS discounting reduction defined in Chapter 13, Section 3. The source for these codes is the American Medical Association (AMA) Current Procedural Terminology (CPT) guide.

b. Discounting for Bilateral Procedures.

NOTE: Bilateral codes can be surgical and non-surgical.

(1) Following are the different categories/classifications of bilateral procedures:

(a) Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).

(b) Inherent bilateral (i.e., procedure in and of itself is bilateral).

(c) Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures).

(2) Terminated bilateral procedures or terminated procedures with units greater than one should not occur. Line items with terminated bilateral procedures or terminated procedures with units greater than one are denied.

(3) Inherent bilateral procedures will be treated as a non-bilateral procedure since the bilateralism of the procedure is encompassed in the code.

(4) The above bilateral procedures will be discounted based on the application of discounting formulas appearing in Chapter 13, Section 3, paragraph III.A.5.c.(6) and (7).

c. Modifiers for Discounting Terminated Surgical Procedures.

(1) Industry standard modifiers may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers are essential for ensuring accurate processing and payment of these claim types.

(2) Industry standard modifiers are used to identify surgical procedures which have been terminated prior to and after the delivery of anesthesia.

(a) Modifiers 52 and 73 are used to identify a surgical procedure that is terminated prior to the delivery of anesthesia and is reimbursed at 50% of the allowable; i.e., the Ambulatory Surgery Center (ASC) tier rate, the Ambulatory Payment Classification

(APC) allowable amount for OPPS claims, or the CHAMPUS Maximum Allowable Charge (CMAC) for individual professional providers.

(b) Modifiers 53 and 74 are used for terminated surgical procedures after delivery of anesthesia which are reimbursed at 100% of the appropriated allowable amounts referenced above.

2. Exceptions to the above policy prior to implementation of the hospital OPPS, are:

a. If the multiple surgical procedures involve the fingers or toes, benefits for the third and subsequent procedures are to be limited to 25% to the prevailing charge.

b. Incidental procedures. No reimbursement is to be made for an incidental procedure.

3. Separate payment is not made for incidental procedures. The payment for those procedures are packaged within the primary procedure with which they are normally associated.

4. Data which is distorted because of these multiple surgery procedures (e.g., where the sum of the charges is applied to the single major procedure) must not be entered into the data base used to develop allowable charge profiles.

5. The OPPS inpatient only list shall apply to OPPS, non-OPPs, and professional providers. Refer to [Chapter 13, Section 2, paragraph III.D](#). The inpatient only list is available on TMA's web site at <http://www.tricare.mil/inpatientprocedures>.

B. Multiple Primary Surgeons. When more than one surgeon acts as a primary surgeon for multiple procedures during the same operative session, the services of each may be covered.

C. Assistant Surgeons. See [Chapter 1, Section 17](#).

D. Pre-Operative Care. Pre-operative care rendered in a hospital when the admission is expressly for the surgery is normally included in the global surgery charge. The admitting history and physical is included in the global package. This also applies to routine examinations in the surgeon's office where such examination is performed to assess the beneficiary's suitability for the subsequent surgery.

E. Post-Operative Care. All services provided by the surgeon for post-operative complications (e.g., replacing stitches, servicing infected wounds) are included in the global package if they do not require additional trips to the operating room. All visits with the primary surgeon during the 90 day period following major surgery are included in the global package.

NOTE: This rule does not apply if the visit is for a problem unrelated to the diagnosis for which the surgery was performed or is for an added course of treatment other than the normal recovery from surgery. For example, if after surgery for cancer, the physician who

performed the surgery subsequently administers chemotherapy services, these services are not part of the global surgery package.

F. Re-Operations for Complications. All medically necessary return trips to the operating room, for any reason and without regard to fault, are covered.

G. Global Surgery for Major Surgical Procedures. Physicians who perform the entire global package which includes the surgery and the pre- and post-operative care should bill for their services with the appropriate CPT code only. Do not bill separately for visits or other services included in this global package. The global period for a major surgery includes the day of surgery. The pre-operative period is the first day immediately before the day of surgery. The post-operative period is the 90 days immediately following the day of surgery. If the patient is returned to surgery for complications on another day, the post-operative period is 90 days immediately after the last operation.

H. Second Opinion.

1. Claims for patient-initiated, second-physician opinions pertaining to the medical need for surgery may be paid. Payment may be made for the history and examination of the patient as well as any other covered diagnostic services required in order for the physician to properly evaluate the patient's condition and render a professional opinion on the medical need for surgery.

2. In the event that the recommendations of the first and second physician differ regarding the medical need for such surgery, a claim for a patient-initiated opinion from a third physician is also reimbursable. Such claims are payable even though the beneficiary has the surgery performed against the recommendation of the second (or third) physician.

I. In-Office Surgery. Charges for a surgical suite in an individual professional provider's office, including charges for services rendered by other than the individual professional provider performing the surgery and items directly related to the use of the surgical suite, may not be cost-shared unless the suite is an approved ambulatory surgery center.

J. On May 1, 2009 (implementation of OPSS), surgical procedures will be discounted in accordance with the provisions outlined in [Chapter 13, Section 3, paragraph III.A.5.b.](#) and [c.](#) Multiple discounting will not be applied to the following CPT¹ procedure codes for venipuncture, fetal monitoring and collection of blood specimens; 36400-36416, 36591, 36592, 59020, 59025, 59050, and 59051.

- END -

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