SURGICAL GUIDELINES

INCLUSIVE SURGICAL POLICY

- The maximum reimbursement for a pre-operative surgical visit for an established patient shall be $107.17. The CPT level of service must be supported by office notes.
- The surgical procedure itself.
- Local anesthesia, such as infiltration, digital or topical anesthesia. (For regional anesthesia - modifier codes should be used by the physician in accordance with CPT rules.)
- In-patient hospital visits. When extenuating circumstances require a patient to remain hospitalized beyond a standard length of stay, charges for in-patient hospital visits may be submitted for individual consideration.
- First routine post-operative office visit.

FEE "UNBUNDLING" AND UNIFORM DEFINITION FOR SURGICAL PROCEDURES

Procedures that are an integral part of the main operation should be considered as necessary adjuncts not separate entities. Surgical procedures shall be billed based upon uniform definitions, rules and guidelines found in the most current version of the National Correct Coding Initiative (NCCI) (The "Medicare global fee period" included in the definition will not be used). Further information on this publication is available at:

http://www.cms.gov/NationalCorrectCodInitEd/

The NCCI Edits Manual may also be obtained by purchasing the manual, or sections of the manual, from the National Technical Information Service (NTIS) by contacting NTIS at 1-800-363-2068 or 703-605-6060 or at http://www.ntis.gov/products/cci.aspx

MULTIPLE SURGERIES

Payment for multiple surgeries - same incision and/or anatomical site, billed in accordance with the unbundling rule above, will be as follows:

- 100% of the practitioner payment amount for the primary procedure
- 50% of the practitioner payment amount for the secondary procedure
- 30% of the practitioner payment amount for the third, fourth, or fifth procedures.

Payment for multiple surgeries - different incision and/or anatomical site, billed in accordance with the unbundling rule above, will be as follows:

- 100% of the practitioner payment amount for the primary procedure
- 50% of the practitioner payment amount for the second, third, fourth, or fifth procedures.

The above multiple surgeries rule shall not apply to an emergency surgery. Emergency surgery is surgery that is generally performed within twenty-four (24) hours of a traumatic injury. Charges for an emergency surgery shall be submitted for individual consideration. Emergency surgery is subject to the above inclusive surgical policy and fee unbundling and uniform definition for surgical procedures.

**As of 10/15/2014 Add-On Codes as published by the American Medical Association in the most recent issue of the Physician's Current Procedural Terminology shall be exempt from the multiple surgery rules.