Policy

Blue Cross Blue Shield of Massachusetts (BCBSMA)* reimburses contracted professional providers for covered surgical services in accordance with their provider contracts and network fee schedules. The global rate includes pre-operative, surgical care, and post-operative services as follows: major surgery - 90 days; minor surgery - 10 days. (Not applicable to endoscopic surgery).

General Benefit Information

Services and subsequent payment are based on the member’s benefit plan and provider Agreement. Providers and their office staff may use our electronic technologies to verify effective dates and members’ cost share prior to initiating services. Please visit our Technology Tools page to access links that will provide information on member eligibility and benefits. Member liability amounts may include, but are not limited to copayments, deductible, and/or co-insurance and will be applied depending upon the member’s benefit plan.

Payment Information

Providers are reimbursed according to the Plans’ network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

In the case of multiple procedures, the clinically more intense primary procedure is reimbursed in full. The less clinically intensive secondary procedures are paid at 50% of that procedure’s allowance. The fee reduction can not be balance-billed to the patient.

The following services are included in the payment allowance for the global surgical package:

Pre-operative Care:
- Pre-operative visits by the surgeon on the day before or the day of major surgery
- The hospital admission work-up.

Surgery:
- The surgical procedure.

Post-operative Care:
The post-operative periods that apply are as follows: major surgery - 90 days; minor surgery - 10 days. (Not applicable to endoscopic surgery). Services include, but are not limited to, the following:
- Immediate post-operative care, including dictating operative notes and talking with the family and other physicians
- Written orders
- Evaluation of the patient in the recovery room
- Post-operative follow-up care on the day of the surgery
- Post-operative hospital visits, including the post-operative pain management
- Post-operative office visits when related to recovery from the surgery
- Complications following surgery: all additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications that do not require additional trips to the operating room.
- Removal of packs
- Dressing changes
- Removal of skin suture, staple, lines, wires, tubes, drains, casts, and splints
- Local incision care
- Insertion, irritation, and removal of urinary catheters
- Routine peripheral IV lines and nasogastric and rectal tubes
- Intra-operative services (i.e., all procedures that are usually included as a necessary component of a surgical procedure).
Billing Information

When submitting claims for reimbursement, providers should report all services:

- Using the most up-to-date industry-standard procedure, revenue, and diagnosis codes
- Including modifiers where applicable
- Submitting the modifier that will impact payment in the first modifier field, followed by informational modifiers.

Procedure codes should be referenced from the current CPT®, HCPCS Level II, revenue code, and/or ICD-9-CM manuals, as recommended by the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to HCPCS, ICD-9, and CPT codes and definitions.

For information about electronic or paper claims submission, please refer to the Billing and Reimbursement section of the Blue Book.

Document History

12/1/2009 – original documentation of payment policy.

* Reference to “the Plans” refers to both BCBSMA and BCBSMA HMO Blue.