Limited Coverage for Major Surgeries in a Non-facility Setting

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Scope and history

This guide applies to all providers, non-physician providers and subcontractors who submit surgical service claims. The purpose of this guide is to provide direction on CareOregon policy for major surgery billed in a non-facility setting.

The Centers for Medicare & Medicaid Services (CMS) defines a major surgery as a procedure that has a 90-day global period.

Major surgeries generally need to be performed in facilities like hospitals or ambulatory surgical centers (ASCs) because they require specialized equipment, staff, and emergency care capabilities. Non-facility settings, such as physician offices, are typically limited to minor procedures that do not demand extensive resources. According to Oregon Administrative Rules (OAR) 410-130-0380, major surgeries must be conducted in licensed facilities such as hospitals or ASCs. These regulations ensure that surgeries are carried out in environments equipped with the necessary resources and emergency care capabilities.

Under the resource-based system of the Medicare Physician Fee Schedule, CMS has developed practice expense relative value units specific to the facility and non-facility settings. Values were not created for some non-facility practice expense services which, either by definition or in practice, are never (or rarely) performed in a non-facility setting. Many major surgical procedures with a 90-day global period are almost always performed in the hospital inpatient setting. These facility-only codes are identified by a “NA” in the “NA Indicator” field.

Policy/guidelines

In order to reduce overpayments caused by erroneous billing errors, CareOregon has implemented a process to deny most major surgeries when performed in a non-facility setting. The denial will apply to professional services billed with the following Place of Service (POS) codes: 01, 03, 04, 09, 11, 12, 13, 14, 15, 16, 17, 20, 25, 32, 33, 49, 50, 54, 55, 57, 60, 62, 65, 71, 72, 81 and 99.

Based on clinical standards, an exception was made for certain major surgeries to allow them to continue to be paid for when performed in a non-facility setting. The following types of surgeries will be allowed in a non-facility setting: fracture treatment, cataract and Lasik eye surgery, and vasectomy.

If a claim denies due to being a major surgery performed in a non-facility setting, providers can submit for reconsideration of the charges. The following items will be used in the reconsideration process:

- Clinical documentation must support the codes billed on the claim.
  Note: often the electronic health record presents a short description of a procedure that does not

provide all of the information necessary for correct code selection. Please confirm that the code selected for billing is a match to the procedure that was performed and documented in the medical record

- Reconsideration should include a copy of the final pathology report when applicable
- CareOregon clinical team will evaluate if the surgery was appropriate, safe and effective in a non-facility setting

References

Physician Fee Schedule | CMS
https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0380
Oregon Secretary of State Administrative Rules Public Health Division Chapter 333 ASC