



Policy Information

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| Policy Manual | Provider Reimbursement Policy Manual | Original Effective Date | 12/2025 |
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Policy Applicability (LOB)

| | | | |
|--|---|--|--|
| <input checked="" type="checkbox"/> Medicare Inc | <input checked="" type="checkbox"/> Commercial IA | <input checked="" type="checkbox"/> Commercial IL | <input checked="" type="checkbox"/> Health Choices |
| <input checked="" type="checkbox"/> Medicare WI | <input checked="" type="checkbox"/> Commercial WI | <input checked="" type="checkbox"/> CPPHP (Kansas) | |

Policy Statement and Purpose

This policy addresses the criteria for reimbursement for the surgical services indicated herein. The stipulations are based on CMS coding and payment requirements. CMS updates these files quarterly. It is the provider's responsibility to follow the guidelines for the date of service that services were rendered. If coding is inconsistent with CMS guidelines, payment may be denied. Where CMS is silent, industry standards have been applied. Adhering to these guidelines does not imply payment, only eligibility for reimbursement. Actual payment for services will be guided by the services documented in the medical record and the coverage criteria in the patient's contracted medical plan for whom the services are rendered.

This policy is expressly incorporated into and made a part of all reimbursement agreements and will provide context and clarity to the extent there is ambiguity in payment terms and notwithstanding contrary claims with regard to industry standards or practices.

The following categories for reimbursement and coding guidelines for surgical services are addressed in this policy:

- [SURGICAL PROCEDURES](#)
- [SURGERY ASSISTANTS](#)
- [SURGERY TIMELINES: GLOBAL PERIOD](#)
- [COMPONENTS OF GLOBAL SURGICAL PACKAGE](#)

Policy Definitions

Allowed Amount: The contracted rate or billed charge depending on whether the provider is in-network or out-of-network.

Assistant-at-Surgery: A provider who actively assists the surgeon in charge of a surgical procedure. This can include various healthcare professionals such as physicians, nurse practitioners, or clinical nurse specialists. The Assistant-at-Surgery at surgery provides more than just ancillary services and must be documented in the operative note.

Assistant Surgeon: A Physician (M.D. or D.O.) who actively assists the primary surgeon during a surgical procedure. Such an individual is usually trained in the same specialty as the surgeon. The services provided by the Assistant Surgeon must be documented in the operative note.

Bilateral Procedure: The same procedure performed on both sides of the body during the same operative session.

CMS: Centers for Medicare and Medicaid Services.

Critical/Key Portions of Surgical Procedure: CMS does not define “critical” or “key” but leaves it to the discretion of the surgeon. MAHP also leaves to the surgeon’s judgment the critical or key portions of a procedure but indicates that essential technical expertise and surgical judgment are required to achieve optimal outcomes for the patient. The critical/key portion of the operation should be made known to all operating room staff.

Concurrent Surgery: Surgical procedures where critical portions of the operation is performed by a single surgeon on different patients, and in different rooms, during the same period of time.

CPT: Current Procedural Terminology. A medical code set maintained by the American Medical Association (AMA) that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT is included in Level I Healthcare Common Procedure Coding System (HCPCS).

Co-Surgeon: Physician who may or may not be trained in the same specialty as the primary surgeon. Co-surgeons work together with the primary surgeon during complex surgical procedures where each surgeon performs distinct parts of an operation. The Co-surgeon always performs their work during the same encounter as the primary surgeon.

Double-Booked Surgery: See Concurrent Surgery.

Evaluation and Management Services (E/M): Services that require three key components: problem or comprehensive history examination, medical decision making, counseling and/or coordination of care with physician or other qualified health care provider.

HCPCS: Healthcare Common Procedure Coding System.

Hospital Acquired Condition (HAC): A condition that is not present when the patient arrives or is admitted to the hospital or other facility owned by the hospital but occurs during or after the stay.

Iatrogenic Complication: An adverse condition that is a direct result of treatment by a physician or other health care professional.

Immediately Available: Reachable and with the ability to provide, on demand, the appropriate level of clinical care necessary to achieve an optimal surgical outcome.

Implant: An object, device or material that is inserted surgically, or embedded via surgical or nonsurgical means, or grafted into the body with the exception of skin substitutes and remains in the body either indefinitely for prosthetic and/or therapeutic purposes or remains in the body for a period of time for diagnostic and/or therapeutic purposes.

Implant Components: Implant integral parts such as screws, plates, rods, etc., remaining in the body used in conjunction with the primary implant.

Implant Supplies: Elements such as tools or implant kits or implant systems used to place or remove implants but do not remain in the body.

Informed Consent: Process where communication between a patient and a physician results in the patient’s (or surrogate’s) authorization to proceed with a specific medical intervention. The informed consent is in writing and included in the medical record.

Inpatient: Admission to a hospital or skilled nursing facility on a physician’s order.

Modifier: Two characters (letters or numbers) appended to a CPT or HCPCS Level II code. The modifier provides additional information about the medical procedure, service, or supply involved without changing the meaning of the code.

Modifier -22: Increased Procedural Services.

Modifier -24: Unrelated Evaluation and Management Services by the same physician or other Qualified Health Care Professional during a post operative period.

Modifier -25: Significant, separately identifiable evaluation and management service by the same physician or other Qualified Healthcare Professional on the same day of the procedure or other service.

Modifier -50: Bilateral procedure. This modifier should not be used when “bilateral” or “unilateral or bilateral” is used in the CPT code descriptor.

Modifier 54: A surgeon performed only the surgical portion of a procedure and that postoperative care has been transferred to another provider.

Modifier 55: One physician performs the surgery and another physician provides the post-operative care.

Modifier -57: Decision for surgery.

Modifier -58: Staged or related procedure or service by the same physician or other Qualified Health Care Professional during the post operative period.

Modifier -76: Repeat procedure or service by the same physician or other Qualified Health Care Professional.

Modifier -77: Repeat procedure or service by another physician or other Qualified Health Care Professional.

Modifier -78: Unplanned return to the operating/procedure room by the same physician or Other Qualified Health Care Professional following initial procedure for a related procedure during the post operative period.

Modifier -80: Assistant Surgeon.

Modifier -81: Minimum Assistant Surgeon.

Modifier -82: Assistant Surgeon when qualified resident surgeon is not available.

Modifier -AS: Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant-at-surgery.

Multiple Procedure Reductions: A reduction of the payment for second and subsequent procedures performed during a single patient encounter on the same day.

Overlapping Surgery: Procedures in which part or all of the procedures chronologically coincide and when the patient’s care is left with another qualified medical provider. More specifically, operations are spaced out to ensure the critical portions of each operation, for which a single surgeon is responsible, do not occur at the same time.

Primary Surgeon: The principal surgeon involved in the specific critical portions of a surgical procedure.

Qualified Healthcare Professional: Physician assistant or clinical nurse specialist who is not a licensed M.D. or D.O. or nurse practitioner.

Qualified Healthcare Practitioner: A physician or other qualified health care professional who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Robotic Surgery: A method to perform surgery using very small tools attached to a robotic arm. The surgeon controls the robotic arm with a computer.

Running Two Rooms: See Concurrent Surgery.

Simultaneous Operations: See Concurrent Surgery.

Team Surgeon: Three or more surgeon who operate in a surgical team during a highly complex surgical procedure. The surgeons in such a team are often trained in different specialties.

Timeout Process: An immediate pause by the entire surgical team to confirm the correct patient, procedure, and site.

TIN: Taxpayer Identification Number.

Policy Provisions and Required Procedures

SURGICAL PROCEDURES

- BILATERAL SURGICAL PROCEDURES**

What is a bilateral surgical procedure?

A bilateral surgical procedure is when the same procedure is performed on both sides of the body during the same operative session.

How should bilateral procedures be billed?

Billing bilateral procedures is dependent on the claim form:

| | CMS UB-04 | CMS 1500 |
|------------------------------|------------------|-----------------|
| Claim lines | 2 | 1 |
| Units of service/line | 1 | 1 |
| Modifiers | RT and/or LT | 50* |

**Do not append modifier -50 when the code descriptors state "bilateral" (CPT 27395) or "unilateral or bilateral" (CPT 52290).*

Are there payment adjustments when billing bilateral procedures?

Applicable payment adjustments may apply depending on the CPT code billed. Each CPT code is assigned a Bilateral Status Indicator. This will determine the bilateral reduction adjustment appropriate for the CPT code that is billed. The chart below determines what the eligible reimbursement is for each bilateral status indicator. The *Bilateral Status Indicators* for relevant CPT codes are listed in CMS **National Physician Fee Schedule Relative Value (NPF SRV) Files** and updated quarterly. [PFS Relative Value Files | CMS](#)

| Bilateral Status Indicator | Description | Bilateral Reduction Adjust | Eligible Reimbursement |
|-----------------------------------|--|-----------------------------------|---------------------------------|
| 0 | Unilateral procedure | N/A | 1 unit is reimbursed |
| 1 | Bilateral procedure | 50% | 150% of applicable fee schedule |
| 2 | Unilateral or bilateral procedure | N/A | 1 unit is reimbursed |
| 3 | Radiology or other diagnostic procedures | N/A | Number of procedures performed |
| 9 | Bilateral concept does not apply | N/A | N/A |

- **ROBOTIC-ASSISTED SURGERIES**

Are robotic assisted surgeries eligible for reimbursement?

CMS recognizes robotic surgeries as another surgical type of surgical procedure. Such surgical techniques are eligible for reimbursement provided that the surgery is medically necessary and the robotic-assisted technique is approved by FDA. Examples of FDA approved robotic assisted surgeries are for colectomies, hysterectomies and knee replacements to name a few. MAHP conforms to CMS guidelines for robotic-assisted surgeries.

Is the equipment used to perform robotic-assisted surgeries eligible for separate reimbursement?

No equipment of any type for any procedure is eligible for separate reimbursement. Additionally, billing CPT S2900 (*Robotic Assisted Devices*) or appending modifier -22 (*Increased Procedural Services*) when robotic equipment is used will not allow additional reimbursement but will, in fact, deny the charge. See *Reimbursement Policy: Items, Services and Therapies that are Not Payable* for more information on non-reimbursable services and supplies.

Robots cannot be billed as assistant surgeon services. Appending modifiers designated for assistants-at-surgery (80,81,82 of AS) will not override the edit and such charges will be denied.

- **CONCURRENT SURGERIES (OVERLAPPING SURGERIES, RUNNING TWO ROOMS, DOUBLE-BOOKED SURGERY, SIMULTANEOUS OPERATIONS)**

MAHP conforms to the specific guidelines established by CMS for concurrent surgeries except as indicated within this policy. It is recognized that such surgeries occur primarily at university hospitals but the stipulations apply to all facilities that permit concurrent surgeries.

How does CMS define concurrent surgeries?

A scenario where the critical or key portions of two procedures are staggered in time, provided the attending surgeon is present for all critical or key portions of each surgery and a qualified backup physician is immediately available during non-critical phases.

CMS does not define “critical” or “key” but leaves it to the discretion of the surgeon. MAHP also leaves to the surgeon’s judgment the critical or key portions of a procedure but indicates that essential technical expertise and surgical judgment are required to achieve optimal outcomes for the patient. The critical/key portion of the operation should be made known to all operating room staff.

CMS permits only two concurrent surgical procedures to be eligible for reimbursement. If a surgeon is engaged in three or more concurrent surgeries, these are not eligible for reimbursement. Services during such surgeries are considered advisory in nature as direct patient care is not tenable.

How are concurrent surgeries reimbursed?

- Concurrent surgeries are eligible for reimbursement for both surgeries provided the primary surgeon has clearly documented in the medical records all of the following:
 - Surgeon’s presence during the timeout period
 - Surgeon was present during the key and critical portion of the surgery
 - Surgeon assigned a qualified individual to perform the non-critical portions of the surgery
- Medically necessary anesthesia is eligible for reimbursement for concurrent procedures. However, anesthesia services will not be reimbursed to either the anesthesiologist or surgeon if the patient is under anesthesia longer than is medical necessary.

What are the requirements for disclosure to patients of the surgeon’s intent to perform concurrent surgeries?

While CMS has no requirements for informed consent to patients whose surgeon’s will be performing concurrent surgeries, MAHP holds to the American Medical Association position on informed consent:

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. Transparency with patients regarding all medically appropriate options of treatment is critical to fostering trust and should extend to any discussions regarding who has access to patients' health data and how data may be used.

[American Medical Association Informed Consent](#)

MAHP strongly urges primary surgeons, whose intent is to perform concurrent surgeries, to provide disclosure to patients prior to such surgical procedures and obtain informed consent. If this is not possible due to the urgency of the circumstances, then the patient should be so informed in writing subsequent to the procedure.

- **IMPLANT SURGERIES**

Implant and implant components are eligible for separate reimbursement when the implanted device or component conforms to the definition of "implant" stated herein:

An object, device or material that is inserted surgically, or embedded via surgical or nonsurgical means, or grafted into the body with the exception of skin substitutes and remains in the body either indefinitely for prosthetic and/or therapeutic purposes or remains in the body for a period of time for diagnostic and/or therapeutic purposes.

Exception: Implants charges on claims that are reimbursed at a Case Rate Payment Methodology are not eligible for separate reimbursement.

How are implant charges reimbursed?

Unless otherwise stipulated in the provider contract, reimbursement requests for implants must be accompanied by the implant invoice. Disregarded requests for invoices may result in the denial of the implant charge.

MAHP will not reimburse implant charges under the following conditions/situations:

- Implants found to be incorrect during the surgical procedure
 - Example: Implant screw removed due to length and replaced with a screw of the correct length. The screw that was removed will not be reimbursed. The replacement screw is eligible for reimbursement.
- Implants fall out of sterile field
 - Example: Plate intended for implant was dropped and falls out of sterile field. This breach of sterile technique renders the implant unusable. This implant is not eligible for reimbursement.
- Implants that malfunction during the surgical procedure
 - Example: Implanted pacemaker does not function as required and is removed. The pacemaker that was removed will not be reimbursed. The replacement pacemaker is eligible for reimbursement.

The following supplies are not eligible for separate reimbursement. (For additional information on non-reimbursable supplies, see ***Reimbursement Policy: Items, Services and Therapies that are Not Payable***)

- Tools, instrumentation, kits, procedural trays, OR packs of any type including disposable and reusable items
- Casting and splinting supplies
- Skin substitutes
- Closure devices of any type (hemostats, staples, sutures, clips, glue, gelatins, collagens, enzymes, fibrins, etc.)
- Monitoring devices
- Compression systems
- Drugs, any used in the pre/peri/post operative periods
- Irrigation and suction supplies
- Skin prep supplies
- Common surgical supplies including gowns, gloves, towels, drapes, dressings, tubing, needles, catheters, etc.
- Programming services
- Anesthesia supplies

SURGERY ASSISTANTS

What provider types are eligible for reimbursement when assisting in surgical services?

Medical Associates Health Plans reimburses any Qualified Healthcare Professionals and Qualified Healthcare Practitioners who are eligible to receive reimbursement according to the reimbursement rates, modifiers, and Surgical Indicator Codes stipulated by CMS. In general, surgical services performed by students will not be reimbursed and the primary surgeon will not be reimbursed.

If multiple procedures are performed by more than one surgeon, multiple procedure reductions will apply.

| Qualified Healthcare Professional/Practitioner | Modifier | Rate of the MPFS ¹ | Assistant at Surgery Indicator Code ² | Procedure CPT same as surgeon? | How many may assist per surgery? |
|--|----------|-------------------------------|--|--------------------------------|----------------------------------|
| Assistant-at-Surgery (MD, DO) | AS | 16% | 2 or 0 | Y | 1 |
| Assistant-at-Surgery (PA, NP, CNS, CNM) | AS | 13.6% | 2 or 0 | Y | 1 |
| Assistant Surgeon ³ | 80 | 16% | 2 or 0 | Y | 1 |
| Co-Surgeon ⁴ | 62 | 62.5% | 2 or 0 | N | >1 |
| Team Surgeon (See footnote for special stipulations ⁵) | 66 | Case by case | 2 or 0 | N | >1 |
| Minimum Assistant Surgeon | 81 | 16% | 2 or 0 | Y | 1 |
| Assistant Surgeon when qualified resident surgeon not available | 82 | 16% | 2 or 0 | Y | 1 |

¹Rate is a percentage of the Medicare Physician Fee Schedule (MPFS) or as indicated in the provider contract and based on the allowed amount for the surgical procedure eligible for payment

²Assistant at Surgery Indicator Code

0 - Assistant surgeon may be paid with documentation supporting medical necessity.

1 - Assistant surgeon cannot be paid.

2 - Assistant surgeon can be paid.

³Services of Assistant Surgeon is not eligible for reimbursement when a co-surgeon is present and uses the same CPT as the primary surgeon.

⁴If a bilateral procedure is being performed the co-surgeon must append both modifiers 50 and 62 to the procedure code.

⁵Special stipulations for team surgeons: Preauthorization for a team surgery is required. Each surgeon of the team must document their specific participation in the procedure in order to be eligible for reimbursement. One operative note for the entire team will not suffice.

What provider types are NOT eligible for reimbursement when assisting in surgical procedures?

- Registered Nurses (RN)
- Registered Nurse First Assistant (RNFA)
- Certified Surgical Assistant (CSA)
- Certified First Assistant (CFA)
- Certified Surgical First Assistant (CSFA)

SURGERY BILLING

How should surgical services be billed?

- Surgical services should be billed with revenue code 036X as appropriate.
- Providers may bill service units by either number of procedures or duration of the procedure as long both the UB-04 and the itemized bill (IB) are consistent in billing units.
- Claims that bill the surgical service by number of procedures on the UB-04 and bill time in minutes on the IB or vice versa, those charges will be denied. Provider may submit a corrected claim with consistent billing units.

SURGERY TIMELINES: GLOBAL PERIOD

What are Global Surgical Periods and how does reimbursement work?

CMS stipulates that routine and necessary services related to the surgery are included in the fee for the surgical procedure and are not eligible for separate reimbursement during the preoperative, intraoperative, and postoperative period known as the **Global Period**. The Global Period is dependent on the complexity of the surgical procedure and this is determined by the CPT code.

CMS publishes a schedule of *Surgical Indicators* for CPT codes. The *Surgical Indicators* for relevant CPT codes are listed in CMS **National Physician Fee Schedule Relative Value (NPFSSRV) Files** and updated quarterly. [PFS Relative Value Files | CMS](#)

MAHP will reimburse services related to the procedure according to the *Surgical Indicator* for the procedures' CPT codes. Services that are rendered within the Global Period are not eligible for separate reimbursement. This applies to both facility and professional (E/M) services.

The CMS descriptions of the *Surgical Indicators* are below:

| Surgical Indicator | Description |
|---------------------------|--|
| 000 | <ul style="list-style-type: none">• No pre-operative period• No post-operative days• Generally, an E/M visit on the procedure day isn't payable as a separate service.• Example: Endoscopies and some minor procedures |
| 010 | <ul style="list-style-type: none">• No pre-operative period• Generally, a visit on the procedure day isn't payable as a separate service• Total global period is 11 days; count the surgery day and the 10 days following the surgery day• Example: Other minor procedures |
| 090 | <ul style="list-style-type: none">• 1-day pre-operative included• Generally, the procedure day isn't separately payable• Total global period is 92 days; count 1 day before surgery, the day of surgery, and the 90 days following the surgery day• Example: Major procedures• Exception: The post-discharge home visit is eligible for separate reimbursement when service is performed by surgeon and other Qualified Healthcare Professionals |
| MMM | Maternity codes; usual global period doesn't apply. |
| XXX | Global concept doesn't apply. Example: CPT G9685, G9686 |
| YYY | A/B MAC decides whether global concept applies and establishes postoperative period at time of pricing. Check MAC for your area. |
| ZZZ | Code related to another service. CMS always includes it in the global period of the other service. Example: Category III CPT codes (0437T, 0439T, and 0443T) |

Can modifiers be used to obtain payment during the Global Period?

Modifiers should only be used for their intended purpose. Appending one or more modifiers will not override a denial for a service rendered within the Global Period.

If modifiers are appended for a justifiable reason, such as an E/M visit unrelated to the surgical procedure, the medical record must support its use.

How does the Global Period affect a providers operating in a group?

A provider covering for another provider operating within a group (having the same name and TIN) are subject to the stipulations of the Global Period.

COMPONENTS OF THE GLOBAL SURGICAL PACKAGE

MAHP conforms to the CMS guidelines for the Global Surgical Package unless otherwise indicated in this policy.

What is the Global Surgical Package?

CMS defines the global surgical package as all necessary services normally provided by a provider (or members of the same group with the same specialty) before, during, and after a procedure. Providers in the same group practice, with the same specialty, must bill and accept payment as though they're a single physician.

Is global surgery payment restricted to only hospital inpatient settings?

CMS applies global surgery package to any setting including inpatient facilities, outpatient hospitals, ambulatory surgical centers and physicians offices.

What services and supplies are INCLUDED in the Global Surgical Package?

The following services/supplies are considered integral to the procedure and is not eligible separate reimbursement.

- SERVICES

- Pre-operative visits after the decision to operate.
 - Major procedures: includes pre-op visit the day before surgery
 - Minor procedures: includes pre-op visit on day of surgery
- Intra-operative
 - All services that are normally a necessary part of a procedure
- Post-operative
 - All medical and surgical services the surgeon provides during the global surgical period
 - Follow-up post operative recovery visits
 - Post-operative pain management
 - Exception: Complications that require a return visit to the operating room are eligible for separate reimbursement provided that the complications are not related to provider preventable conditions. For more information on healthcare acquired conditions, see ***Reimbursement Policy: Provider Preventable Healthcare Acquired Conditions.***
- Miscellaneous
 - Dressing changes
 - Local incision care
 - Operative pack removal
 - Insertion and removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, splints, urinary catheter, intravenous lines, nasogastric and rectal tubes
 - Irrigation
 - Tracheostomy tube changes and removals

- SUPPLIES

- Any supplies related to the surgical procedure pre-, intra-, and post-operatively are included in the surgery and not separately payable. For more information, see **Reimbursement Policy: Items, Services and Therapies that are Not Payable**.

What services are EXCLUDED from the Global Surgical Package?

The following services are excluded from the Global Surgical Package and eligible for separate reimbursement when the appropriate modifier is appended to the charge.

| SERVICE | MODIFIER |
|---|-------------------------|
| E/M visit on the day before or the day of a major surgical procedure only if the initial decision to perform the procedure was made during that visit. | 57 |
| E/M visit on the same day as a minor procedure only if the E/M visit is unrelated to the procedure performed. | 25 |
| E/M visit during the postoperative period only if the E/M visit is unrelated to the procedure performed. | 24 |
| Repeat surgical procedure by the same surgeon performed on the same day as the original procedure requiring a return trip to the operating room provided that the complications are not related to provider preventable conditions. For more information on healthcare acquired conditions, see Reimbursement Policy: Provider Preventable Healthcare Acquired Conditions . | 76 |
| Repeat surgical procedure by a different surgeon performed on the same day as the original procedure requiring a return trip to the operating room provided that the complications are not related to provider preventable conditions. For more information on healthcare acquired conditions, see Reimbursement Policy: Provider Preventable Healthcare Acquired Conditions . | 77 |
| A procedure that is related to the original procedure that requires an unplanned return to the operating room. | 78 |
| A procedure that is unrelated to the original surgery. | 79 |
| A staged surgical procedure that was planned at the time of the original surgery and performed during the postoperative period of the original surgery. | 58 |
| Transfer of surgical care from one provider to another during the global period. New provider must use the same global surgery services CPT code. | 54 |
| Transfer of post-operative management from one provider to another during the global period. New provider must use the same global surgery services CPT code. | 55 |
| Transfer of pre-operative management from one provider to another during the global period. New provider must use the same global surgery services CPT code. | 56 |
| Critical care services for seriously injured or burned patients during the global surgical period. | Modifier as appropriate |

| | |
|---------------------------------------|---|
| Related Policies | Reimbursement Policy: Provider Preventable Healthcare Acquired Conditions. Reimbursement Policy: Items, Services and Therapies that are Not Payable. |
| Related Training/ Job Aids | |
| NCQA Standard | |

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|--|---|----------------------|------------------|
| References | Status Indicators CMS PFS Relative Value Files CMS American Medical Association Informed Consent Medicare Claims Processing Manual CMS Global Surgery Booklet Medicare Claims Processing Manual/Chapter 12 Robotic surgery: MedlinePlus Medical Encyclopedia Medicare NCCI Policy Manual CMS | | |
| Exhibits | | | |
| Policy Owners / Reviewers | | | |
| Department Owner | Lisa Kuhls | Date Reviewed | 1/2026 |
| Department Reviewer | Network Strategy Committee | Date Reviewed | 1/2026 |
| Approving Committee if applicable | <input type="checkbox"/> Compliance <input checked="" type="checkbox"/> UMC <input type="checkbox"/> QIC <input checked="" type="checkbox"/> Board of Directors <input type="checkbox"/> Other: _____ | Date Approved | 2/2026 3/2026 |
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