Washington State Department of
Labor & Industries

Chapter 23: Surgery

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

Table of Contents Page

Payment policy: All surgery services

General information

This policy includes general information about coverage and limitations for surgical procedures. For more information, see L&I's fee schedules, coverage decisions, and treatment guidelines and resources.

This chapter also contains separate policies related to bilateral surgeries, endoscopies, global surgery, pre-, intra-, and post-operative services, multiple surgeries, and unlisted procedures.

Registered Nurses (RN) as surgical assistants

Licensed registered nurses may be paid to perform surgical assistant services if they submit the following documents to L&I along with their completed provider application:

- A photocopy of their valid and current registered nurse license, *and*
- A letter granting onsite hospital privileges for each institution where surgical assistant services will be performed.

Surgical dressings

Primary surgical dressings are therapeutic or protective coverings directly applied to wounds or lesions on the skin or caused by an opening on the skin. These dressings include items such as:

- Telfa,
- Adhesive strips for wound closure, *and*
- Petroleum gauze.

Secondary surgical dressings serve a therapeutic or protective function and secure primary dressings. These dressings include items such as:

- Adhesive tape,
- Roll gauze,
- Binders, *and*
- Disposable compression material.

Tobacco cessation treatment for surgical care

The department has published a coverage decision for Tobacco Cessation Treatment for Surgical Care.

CPT® codes **99406** and **99407** may be billed for tobacco cessation counseling.

Billing for each claim is limited to a maximum of 8 units of any combination of the 2 codes.

Angioscopy procedures

Angioscopy during therapeutic intervention (CPT® **35400**) is limited to only 1 unit based on its complete code description encompassing multiple vessels.

Note: The work involved with varying numbers of vessels is incorporated in the relative value units (RVUs).

Bone growth stimulators

These HCPCS (billing) codes for bone growth stimulators require prior authorization:

- **E0747** (Osteogenesis stimulator, electrical, noninvasive, other than spinal application), *and*
- **E0748** (Osteogenesis stimulator, electrical, noninvasive, spinal application), *and*
- **E0749** (Osteogenesis stimulator, electrical (surgically implanted)), *and*
- **E0760** (Osteogenesis stimulator, low intensity ultrasound, noninvasive).

The insurer, with prior authorization, pays for bone growth stimulators for specific conditions when medically necessary, including:

- Noninvasive or external stimulators including those that create a small electrical current and those that deliver a low intensity ultrasonic wave to the fracture, *and*
- Implanted electrical stimulators that supply a direct current to the bone.

Bone morphogenic protein (BMP)

The insurer may cover the use of bone morphogenic protein 7 (rhBMP-7) as an alternative to autograft in recalcitrant long bone nonunion where use of autograft isn't feasible and alternative treatments have failed. The insurer may also cover the use of rhBMP-2 for primary anterior open or laparoscopic lumbar fusion at one level between L4 and S1, or revision lumbar fusion on a compromised injured worker for whom autologous bone and bone marrow harvest aren't feasible or not expected to result in fusion.

All of the guidelines for bone morphogenic protein treatment must be met before the insurer will authorize the procedures. In addition, lumbar fusion guidelines must be met.

Bone morphogenic protein-2 (rhBMP-2) isn't covered for use in long bone nonunion fractures.

Bone morphogenic protein-7 (rhBMP-7) isn't covered for use in lumbar fusion.

BMP isn't covered for use in cervical spinal fusion or any other indication.

Chondral defects of the knee

Autologous chondrocyte implants (ACI) isn't covered by the insurer. For more information see, L&I's coverage decision.

Osteochondral Allograft/Autograft Transplantation (OAT) is covered by the insurer with prior authorization. For more information see, L&I's coverage decision.

Closures of enterostomy

Closures of enterostomy **aren't payable** with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy. CPT® code **44139** will be denied if it is billed with CPT® code **44625** or **44626**.

Epidural adhesiolysis

Epidural adhesiolysis is covered under certain conditions. For details, see L&I's coverage decision.

Femoroacetabular impingement (FAI) syndrome

29914 and **29915** are covered when hip labral tear co-occurs with FAI syndrome. Utilization review is required. For details, see L&I's coverage decision.

Fractional ablative laser

Fractional ablative laser fenestration of burn and traumatic scars requires prior authorization.

0479T and **0480T** are covered for fractional ablative laser fenestration of burn and traumatic scars where deemed medically necessary by the insurer to treat scarring that impairs the worker's function. Authorization will be given only for treatment of scarring that resulted from the industrial injury, or treatment thereof.

Fractional ablative laser isn't covered for cosmetic purposes only.

0479T is limited to a max of 1 unit per day per claim.

0480T is limited to a max of 40 units per day per claim.

Lumbar Intervertebral Artificial Disc Replacement

Lumbar intervertebral artificial disc replacements aren't covered. For more information, see L&I's coverage decision.

Meniscal allograft transplantation

Meniscal allograft transplantation is covered under certain conditions. For more information, see L&I's coverage decision.

Skin Cell Substitutes

The insurer covers certain HCPCS codes for skin cell substitutes. For the current list of covered codes, see the Professional Services Fee Schedule.

Stem cell therapy for musculoskeletal conditions

Stem cell therapy for musculoskeletal conditions isn't covered. For details, see L&I's coverage decision.

Payment policy: Bilateral surgeries

Requirements for billing

Bilateral surgeries must be billed as 2 line items:

- Modifier **–50** must be applied to the second line item, *and*
- The second line item is paid at the lesser of the billed charge, or 50% of the fee schedule maximum.

Bilateral surgeries are considered 1 procedure when determining the highest valued procedure before applying multiple surgery rules.

If a procedure is performed bilaterally, but isn't subject to the bilateral surgery rule, it must be billed on a single line with the appropriate number of units, based on the code description.

Link: To see if modifier **–50** is valid with the procedure performed, check the [Professional Services Fee Schedule].

Example 1: Billing for bilateral surgeries

Line item	CPT® code (and modifier)	Maximum payment (non-facility setting)	Bilateral policy applied	Allowed amount
1	**64721**	**$827.12**	—	**$827.12**(1)
2	**64721-50**	**$827.12**	**$413.56**(2)	**$413.56**
			Total allowed amount in non-facility setting:	**$1,240.68**(3)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.

(2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier **–50** is paid at 50% of the value paid for the first line item.

(3) Represents total allowable amount.

Example 2: Billing for bilateral surgeries and multiple procedures

Line item	CPT® code (and modifier)	Max payment (non-facility setting)	Bilateral policy applied	Multiple procedure policy applied	Allowed amount
1	**63042**	**$2,316.28**	—	—	**$2,316.28**
2	**63042-50**	**$2,316.28**	**$1,158.14** (1)	—	**$1,158.14**
				Subtotal:	**$3,474.42** (2,3)
3	**22612-51**	**$2,817.34**	—	**$1,408.67**(4)	**$1,408.67**
				Total allowed amount in non-facility setting:	**$4,883.09**(5)

(1) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier **–50** is paid at 50% of the value paid for the first line item.

(2) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.

(3) Allowed amount for the highest valued procedure is the fee schedule maximum.

(4) The third line item billed with modifier **–51** is paid at 50% of the maximum payment.

(5) Represents total allowable amount.

Payment policy: Endoscopy procedures

General information

For the purpose of this policy, endoscopy is used to refer to any invasive procedure performed with the use of a fiber optic scope or other similar instrument.

Endoscopy family groupings

Endoscopy procedures are grouped into clinically related families. Each endoscopy family contains a base procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an endoscopy family is listed in the Endo Base column in the Professional Services Fee Schedule.

How multiple endoscopy procedures pay

When multiple endoscopy procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

- The endoscopy procedure with the highest dollar value is 100% of the fee schedule value, *then*
- For subsequent endoscopy procedures, payment is the difference between the family member and the base fee (see Example 1, below), *then*
- When the maximum fee for the family member is less than the maximum base fee, the payment is $0.00 for the family member (see Example 2, below), *then*
- No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an endoscopic group.

If more than 1 endoscopic group or other non-endoscopy procedure is billed for the same worker on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see Examples 3 and 4, below).

Multiple endoscopies that aren't related (each is a separate and unrelated procedure) are priced as follows:

- 100% of fee schedule value for each unrelated procedure, *then*
- Apply the standard multiple surgery policy.

Payment limits

Payment isn't allowed for an E/M office visit on the same day as a diagnostic or surgical endoscopic procedure unless:

- A documented, separately identifiable service is provided, *and*
- Modifier **–25** is used.

Example 1: Billing for 2 endoscopy procedures in the same family

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Multiple procedure policy applied	Allowed amount
Base (1)	**29805**	**$867.95**	**$0.00** (2)		—
1	**29820-51**	**$982.28**	**$114.33** (4)	**$57.17** (5)	**$57.17** (6)
2	**29824**	**$1,241.85**	**$1,241.85** (3)		**$1,241.85** (6)
Total allowed amount in non-facility setting:					**$1,299.02** (7)

(1) Base code listed is reference only (not included on bill form).

(2) Payment isn't allowed for a base code when a family member is billed.

(3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(4) Allowed amount for other procedures in the same endoscopy family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(5) Multiple procedure policy applies to these services if the service is billed with another endoscopy in the same family. The first line item billed with modifier **–51** is paid at 50% of the maximum payment.

(6) Amount allowed.

(7) Represents total allowed amount after applying all applicable global surgery policies..

Example 2: Billing for endoscopy family member with fee less than base procedure

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Allowed amount
Base (1)	43235	**$524.39**	—	—
1	43241	**$250.82**	**$0.00** (3)	
2	43243	**$416.48**	**$416.48** (2)	**$416.48** (4)
			Total allowed amount in non-facility setting:	**$416.48** (5)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(3) When the fee schedule maximum for a code in an endoscopy family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.

(4) Allowed amount under the endoscopy policy.

(5) Represents total allowed amount.

Example 3: Billing for 2 surgical procedures billed with an endoscopic group (highest fee)

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Standard multiple surgery policy applied
1	11402	**$316.15**	—	**$158.08** (5)
2	11406	**$582.13**	—	**$291.07** (5)
Base (1)	29830	**$846.37**	—	—
3	29835	**$940.86**	**$94.49** (3)	**$47.25** (5)
4	29838	**$1,093.69**	**$1,093.69** (2)	**$1,093.69** (4)
			Total allowed amount in non-facility setting:	**$1,590.09** (6)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100% of fee schedule value.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

Example 4: Billing for 1 surgical procedure (highest fee) billed with an endoscopic group

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Standard multiple surgery policy applied
1	**23412**	**$1,552.16**		**$1,552.16** (4)
Base (1)	**29805**	**$867.95**		
2	**29820**	**$982.28**	**$114.33** (3)	**$57.17** (5)
3	**29824**	**$1,241.85**	**$1,241.85** (2)	**$620.93** (5)
			Total allowed amount in non-facility setting:	**$2,230.26** (6)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100% of fee schedule value.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

Payment policy: Global surgery

Global surgery follow up periods

Many surgeries have a follow up period during which charges for normal post-operative care are **bundled** into the global surgery fee.

The global surgery follow up period for each surgery is listed in the 'FOL UP' column in the Professional Services Fee Schedule.

A new post-operative period begins with the subsequent procedure.

What is included in the follow up period

The follow up period always applies to the following CPT® codes, unless modifier **–24**, **–57** or **–FT** are appropriately used:

- E/M codes:
  - **99212**-**99215**,
  - **99231**-**99239**,
  - **99291**-**99292**,
  - **99304**-**99310**,
  - **99315**-**99316**,
  - **99347**-**99350**,
- Ophthalmological codes: **92012**-**92014**

Link: For information about these requirements, see the Separately billable services policy Chapter 9: Evaluation and Management (E/M), and Appendix B: Modifiers.

The following services and supplies **are included** in the global surgery follow up period and are considered **bundled** into the surgical fee:

- The operation itself, *and*
- Pre-operative visits, in or out of the hospital, beginning once the decision to operate is made and/or on the day before the surgery, *and*
- Services by the primary surgeon, in or out of the hospital, during the post-operative period, *and*
- The following services:
  - Dressing changes, *and*
  - Local incisional care and removal of operative packs, *and*
  - Removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints, *and*
  - Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric, and rectal tubes, *and*
  - Change and removal of tracheostomy tubes, *and*
  - Cast room charges.
- Additional medical or surgical services required because of complications that don't require additional operating room procedures.

What isn't included in the follow up period

The following services and supplies aren't included in the global surgery follow up period and may be separately payable:

- Casting materials, *and*
- The initial **consultation** or evaluation by the surgeon to determine the need for surgery, *and*
- Services of other providers except where the surgeon and the other provider(s) agree on the transfer of care, *and*
- Visits unrelated to the diagnosis of the surgical procedure performed, unless the visits occur due to surgery complications, *and*
- Treatment for the underlying condition or an added course of treatment which isn't part of the normal surgical recovery, *and*
- Diagnostic tests and procedures, including diagnostic radiological procedures, *and*
- Distinct surgical procedures during the post-operative period which aren't reoperations or treatment for complications, *and*
- Treatment for post-operative complications which requires a return trip to the operating room, *and*
- Immunotherapy management for organ transplants, *and*
- Critical care services (CPT® **99291**, **99292**) unrelated to the surgery where a seriously injured or burned worker is critically ill and requires constant attendance of the provider, *and*
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.

In many of these cases, the appropriate modifier must be appended to indicate the service isn't included in the global surgery period. Refer to the relevant policy in this chapter, Appendix B: Modifiers, or the CPT® book for details.

Who must perform these services to qualify for payment

The follow up period applies to any provider who participated in the surgical procedure. These providers include:

- Surgeon or physician who performed any component of the surgery (The pre, intra, and/or postoperative care of the worker; identified by modifiers **–54**, **–55**, and **–56**,),
- Assistant surgeon (identified by modifiers **–80**, **–81**, and **–82**),
- 2 surgeons (identified by modifier **–62**),
- Team surgeons (identified by modifier **–66**),
- Anesthesiologists and CRNAs.

Documentation requirements

Providers, including providers participating in multiple and team surgeries, must submit documentation in workers' individual operative reports to verify the level, type, and extent of surgical services. Surgeons using an assistant surgeon must document the name and actions of the assistant surgeon.

Payment limits

Professional inpatient services (CPT® codes **99221**-**99223**) are only payable during the global period if they are performed on an emergency basis. For example, they aren't payable for scheduled hospital admissions.

Codes that are considered **bundled** aren't payable during the global surgery follow up period.

Supplies used during or immediately after surgery and not sent home with the worker don't meet the definition of **DME** and won't be reimbursed as **DME**.

Pneumatic compression devices used during surgery and sent home with the worker are considered surgical supplies. The cost of the device is **bundled** into the surgical service fee and isn't separately payable, even to **DME** suppliers. For details on coverage of **pneumatic compression devices**, see Chapter 7: Durable Medical Equipment (DME) and Supplies.

Payment policy: Microsurgery

Services that can be billed

CPT® code **69990** is an add-on surgical code that indicates an operative microscope has been used. As an add-on code, it isn't subject to multiple surgery rules.

Payment limits

CPT® code **69990** isn't payable when:

- Using magnifying loupes or other corrected vision devices, *or*
- Use of the operative microscope is an inclusive component of the procedure, (for example the procedure description specifies that microsurgical techniques are used), *or*
- Another code describes the same procedure being done with an operative microscope.

For example, CPT® code **69990** can't be billed with CPT® code **31536** because CPT® code **31536** describes the same procedure using an operating microscope.

Payment policy: Minor surgical procedures

General information

Minor surgical procedures are those that have a global period of 10 or less days. These services may be performed in a physician's office or in a facility setting, as appropriate.

Services that can be billed

For minor surgical procedures, the insurer only allows payment for an evaluation and management (E/M) office visit on the same day and/or during the global period when:

- A documented, significant, unrelated service is furnished during the post-operative period and modifier **–24** is used, or
- The provider who performs the procedure also reports a significant, separately identifiable service on the same date and modifier **–25** is used.

Link: For information about these requirements, see the Separately billable services policy Chapter 9: Evaluation and Management (E/M), and Appendix B: Modifiers.

Services that aren't covered

Modifier **–57**(decision for surgery) isn't payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and an E/M or **consultation** visit isn't paid in addition to the procedure.

Services billed with modifier **–SU** when performed in physician's office aren't covered. Bill without the modifier.

Payment limits

Modifier **–57** is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

Procedures performed in a provider's office are paid at non-facility rates, which includes office expenses. The provider's office must meet ASC requirements to qualify for separate facility payments.

Link: For information about ASC requirements, see WAC 296-23B.

Payment policy: Pre, intra, or post-operative services

Services that can be billed

The insurer will allow separate payment when different providers perform the pre-operative, intra-operative, or post-operative components of the surgery.

Link: Pre and post operative evaluation and management (E/M) services are typically **bundled** in the procedure and aren't separately payable. For more information on when these services are covered outside the global surgical period, see Chapter 9: Evaluation and Management (E/M).

Requirements for billing

When different providers perform pre-operative, intra-operative, or post-operative components of the surgery, modifiers (**–54**, **–55**, or **–56**) must be used.

If different providers perform different components of the surgery (pre, intra, or post-operative care), the global surgery policy applies to each provider. For example, if the surgeon performing the operation transfers the worker to another provider for the post-operative care, the same global surgery policy, including the restrictions in the follow up day period, applies to both providers.

Link: For information on modifiers, see Appendix B: Modifiers.

Payment limits

When modifiers **–54**, **–55**, or **–56** are billed, the percent of the maximum allowable fee for each component of the global surgery is listed in the Professional Services Fee Schedule.

Payment policy: Standard multiple surgeries

How multiple surgeries pay

When multiple surgeries are performed on the same worker at the same operative session or on the same day, the total payment equals the sum of:

- 100% of the global fee schedule value for the procedure or procedure group with the highest value, according to the fee schedule, and
- 50% of the global fee schedule value for the second through fifth procedures with the next highest values, according to the fee schedule.

When different types of surgical procedures are performed on the worker on the same day, the payment policies will always be applied in the following sequence:

- Multiple endoscopy procedures, *then*
- Other modifier policies, *then*
- Standard multiple surgery policy.

Requirements for billing

All surgical procedure codes subject to the standard multiple surgery policy must be billed as a separate line item.

For additional instructions on billing bilateral procedures, see the payment policy on bilateral procedures in this chapter.

Payment policy: Unlisted surgical procedures

General information

Some covered procedures don't have a specific code or payment level listed in the fee schedule. These services are billed using an unlisted CPT® code.

Requirements for billing

When reporting such a service, the appropriate unlisted procedure code must be billed.

Documentation requirements

Within the surgical report, supporting documentation must include:

- A full description of the procedure or services performed and an explanation of why the services were too unusual, variable or complex to be billed using an established procedure code(s).
- List the most similar procedure code(s) to the services performed, including units of service and appropriate modifiers.

No additional payment is made for the supporting documentation.

Services that aren't covered

Unlisted codes can't be billed when another code describes the service provided.

Unlisted codes aren't appropriate when a service for which a code exists was substantially more complex than typically required. When this occurs, the provider must bill the specific code with modifier **–22** to indicate an increased procedural service was performed. For more information on use of modifier **–22**, see Appendix B: Modifiers.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for Ambulatory Surgery Center (ASC) payment	Washington Administrative Code (WAC) 296-23B
Ambulatory Surgery Center **Fee Schedule**	Fee schedules on L&I's website
Autologous chondrocyte implant (ACI)	Autologous chondrocyte implant coverage decision
Becoming an L&I Provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Bone growth stimulators	Bone growth stimulators coverage decision
Bone morphogenic protein (BMP)	Bone morphogenic protein coverage decision
Condition and Treatment Index	Condition and treatment index on L&I's website
Epidural adhesiolysis	Epidural adhesiolysis coverage decision
Medical treatment guideline for Lumbar fusion arthrodesis	Lumbar fusion arthrodesis treatment guidelines
Meniscal allograft transplantation	Meniscal allograft transplantation coverage decision
Professional Services **Fee Schedules**	Fee schedules on L&I's website
Tobacco Cessation Treatment for Surgical Care	Tobacco cessation treatment for surgical care coverage decision

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

