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Last Review: January 15, 2026
Next Review: January 15, 2028
Effective Date: May 01, 2026

Description

Robotic surgery, computer assisted surgery, and robotically assisted surgeries are terms for technological developments that use robotic systems to aid in surgical procedures.

Computer assisted surgery (CAS) represents a surgical concept and set of methods that use computer technology for pre-surgical planning, and for guiding or performing surgical interventions.

The following payment policy applies to both Robotic and Computer-assisted surgery/navigation.

Policy & Guidelines

Not Eligible

Blue Cross VT does not provide separate or additional reimbursement for the use of robotic or computer assisted surgical systems because payment is included in the reimbursement for the primary procedure. As such when using the add-on codes listed in the coding table below are considered bundled / included as part of the primary surgical procedure and not separately payable, whether billed separately or in conjunction with a primary procedure.

Additionally, any professional or technical services and supplies required exclusively because surgery is performed using robotic or computer assistance are also not eligible for separate or additional payment.

Appending modifier -22[Increased Procedural Services] to a surgical code for the sole purpose of representing the use of robotic or computer-assisted surgical techniques does not warrant nor guarantee additional payment. Submission of medical records are required when

submitting modifier -22 for clinical review to determine if increased procedural services are supported in the documentation to warrant additional reimbursement. Refer to Corporate Payment Policy CPP_06 for additional guidance.

CPT® HCPC Level II Codes indicating robotic surgical system(s) or computer-assisted navigation will be denied as inclusive as they are not eligible for separate payment. Payments for surgical procedures will be the same whether robotic or computer assisted systems are used or not.

Addendum A: Coding Table

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

(Not applicable)

Related Policies

Payment Policy:CPP_06 -22 Modifier

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Policy Implementation/Update Information

This policy was originally implemented on March 1, 2013

Date of Change	Effective Date	Overview of Change
07/11/2024	08/01/2024	Moved to a new template, Provider Billing Guidelines and Documentation Coding Table updated to remove unit designation information – unit designation still apply, removed revenue codes, removed principle procedure codes (ICD-9 PCS), removed moderate sedation reference on code 31627 (code still remains), removed the modifier -22 specific information and link to Modifier -22 Payment Policy (CPP_ 06), updated signature to Dr. Tom Weigel.
01/15/2026	05/01/2026	Payment policy reviewed added the following policy statements: • As such when using the add-on codes listed in the coding table below are considered bundled / included as part of the primary surgical procedure and not separately payable, whether billed separately or in conjunction with a primary procedure. • Appending modifier -22[Increased Procedural Services] to a surgical code for the sole purpose of representing the use of robotic or computer-assisted surgical techniques does not warrant nor guarantee additional payment. Submission of medical records are required when submitting modifier -22 for clinical review to determine if increased procedural services are supported in the documentation to warrant additional reimbursement. Refer to Corporate Payment Policy CPP_06 for additional guidance. • Added code 69990 to coding table.

Approved by **Update Approved: 01/15/2026**

Tom Weigel, MD

Tom Weigel, MD, Chief Medical Officer

Addendum A

Coding Table for Robotic & Computer Assisted Surgery/Navigation

Please note: Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

CPT®/HCPC Codes	
Code	**Description**
+20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)
+31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image- guided navigation. List separately in addition to code for primary procedure(s).
+61781	Stereotactic computer-assisted {navigational) procedure; cranial, intradural. List separately in addition to code for primary procedure(s).
+61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural. List separately in addition to code for primary procedure(s).
+61783	Stereotactic computer-assisted (navigational) procedure; spinal. List separately in addition to code for primary procedure(s).
+69990	Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)
+0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images. List separately in addition to code for primary procedure(s).
+0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images. List separately in addition to code for primary procedure(s).
+S2900	Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)

+ = Add-on code

[1]*Current Procedural Terminology CPT®™ codes and descriptions are the property of the American Medical Association.*