Payment Policy: Split Surgical Care (Modifiers 54/55/56) (Commercial)

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
R20210028	1/01/2021	RPC (Reimbursement Policy Committee)

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY:

ConnectiCare has policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. ConnectiCare will inform you of new policies or changes in policies through updates to the Provider Manual and/or provider news. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in ConnectiCare's policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by ConnectiCare due to programming or other constraints; however, ConnectiCare strives to minimize these variations.

ConnectiCare follows coding edits that are based on industry sources, including, but not limited to; CPT guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. ConnectiCare uses industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how ConnectiCare handles specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, ConnectiCare may deny the claim and/or recoup claim payment.

Overview

ConnectiCare has based this reimbursement policy on the guidelines established by the Centers for Medicare and Medicaid Services (CMS) regarding reimbursement of Split Surgical Care (Global Surgery).

Physicians who furnish the surgery and all of the usual pre-and post-operative care may bill for the global package by entering the appropriate CPT code for the surgical procedure only.

Separate billing is not allowed for visits or other services that are included in the global package unless the physician performing the surgical service provides less than the full global package or Split Surgical Care.

Split Surgical Care occurs when a component of the global surgical care is provided by another physician or health care professional other than the physician performing the surgical service.

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Definitions:

Term:	Definition
Same Group Physician and/or Other Health Care Professional, Same Group Practice	All physicians and/or other health care professionals of the same group reporting the same Federal Tax Identification Number (TIN)
Split Surgical Care	The surgical package consists of the preoperative, surgical and postoperative service. Split surgical care occurs when a component of the surgical package is rendered by a physician other than the physician performing the surgical service.
Surgical (Global) Package	The surgical package, also called global surgery, includes all the necessary services normally furnished by a surgeon before, during, and after a procedure. The following services are included in the surgical package when provided in addition to the surgery: • Pre-operative visits after the decision is made to operate. For major procedures, this includes preoperative visits the day before the day of surgery. For minor procedures, this includes pre-operative visits the day of surgery. • Intra-operative services that are normally a usual and necessary part of a surgical procedure • All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room • Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery • Post-surgical pain management by the surgeon • Supplies, except for those identified as exclusions • Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes
Global Surgery Allowance	A single package allowable fee for the surgery and all of the usual pre-and post- operative care.

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Policy

Consistent with CMS (Centers for Medicare and Medicaid Services) surgical care (global surgery) guidelines, ConnectiCare considers the surgical care furnished by the same group physicians and/or other health care professionals to include preoperative, intraoperative and postoperative management.

In accordance with correct coding guidelines, when components of a global surgical procedure are furnished by different providers, each provider is expected to report only the service they performed and identify that service with the appropriate modifier and with the surgery date listed as the date of service.

Occasionally, the physician who performs the surgical procedure may not always furnish the follow-up care. When this occurs, payment for the postoperative care is split between two or more physicians (Not Same Group Physician/Other Health Care Professional Same Group Practice, not reporting the same TIN). Where a transfer of postoperative care occurs, the receiving physician providing the postoperative follow-up care may not bill for any part of the global services until after he/she has seen the patient for the first postoperative visit/service.

Note: Reimbursement may be reduced; please refer to the Modifier Reference Policy located on our website at https://www.connecticare.com/providers/our-policies/reimbursement-policies.

Applicable Modifiers:

Modifier	Description
54	**Surgical Care Only**: When one physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.
55	**Postoperative Management Only**: When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.
56	**Preoperative Management Only:** When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

Reimbursement Guidelines:

- Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier
- Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary's medical record. Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service.

- Where a transfer of care does not occur, the services of another physician may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case
- Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier

Exception: Minor procedures in the Emergency Department

- Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier

Correct procedure code/split care modifier combinations

- Modifier 54: indicates that the surgeon is relinquishing all, or part of, the post-operative care to another physician
- Modifier 55: is billed by the receiving physician, other than the surgeon, who accepts the transfer of care and furnishes post-operative management services.
- Modifier 56: indicates that a physician or qualified health care professional other than the surgeon performed the preoperative care and evaluation prior to surgery.
- Surgical Split-care modifiers 54, 55, and 56 are only valid with surgical procedure codes having a 10- or 90-day global period

For example:

- If a physician performs the surgery only, then the physician will bill for the surgical care only (surgical procedure code) appended with Modifier 54.
- If the same physician performs the preoperative care and surgery, but has turned over the postoperative care to another physician (Not Same Group Physician/Other Health Care Professional, not reporting under the same TIN), then the physician will bill the surgical procedure code appended with Modifiers 54
- Because postoperative care is included in the payment for the surgical package, the physician furnishing the postoperative care should not bill for office visits; instead bill using the surgical procedure code appended with Modifier 55.

Incorrect procedure code/split care modifier combinations

- Modifiers 54, 55, and 56 are not considered valid for obstetric care procedure codes, as specific codes already exist to identify when more than one provider provides antepartum, delivery, and postpartum care.
- Modifiers 54, 55, and 56 do not apply to procedure codes with a 0-day postoperative period.
- Modifiers 54, 55, and 56 are not considered valid for E/M, anesthesia, radiology, laboratory, medicine, or ambulance procedure codes, or any non-surgical HCPCS code.
- A surgeon may not report both modifier 54 and modifier 55 for the same surgical procedure. *The use of modifier 54 indicates the surgeon has transferred postoperative care (partial or total) to another provider, and the surgical code with modifier 55 appended will be billed by the receiving provider to whom the postoperative care was transferred.*
- Modifiers 54, 55, and 56 are not considered valid for provider types to which the global surgery concept and a postoperative care global period do not apply:
    a. Assistant Surgeons
    b. Ambulatory Surgery Centers (ASC)

c. Outpatient Hospital
d. Inpatient Hospital

References

American Medical Association (AMA), Current Procedural Terminology (CPT®) and associated publications and services. CPT® is a registered trademark of the AMA
Centers for Medicare and Medicaid Services (CMS), CMS Manual System and other CMS publications and services including but not limited:

1. 2017 MLN: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf
2. 2017 Rev. 3873, 10/06/17 Medicare Claims Processing Manual Chapter 12/Physicians/Nonphysician Practitioners: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
3. CMS. Medicare Claims Processing Manual (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 40, 40.1, 40.2, and 40.4.
4. CMS. "Global Surgery Fact Sheet."Medicare Learning Network, 2011. July 8, 2013. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

Revision history

DATE	REVISION
1/2021	• New Policy