Commercial Reimbursement Policy

Subject: **Split Care Surgical Modifiers- Professional**	
Policy Number: **C-23004**	Policy Section: **Coding**
Last Approval Date: **06/14/2023**	Effective Date: **06/14/2023**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem allows reimbursement of surgical codes appended with split-care modifiers unless provider, state, or federal contracts and/or requirements indicate otherwise.
Reimbursement is based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code.

The Health Plan will use the standard in the Related Coding section below.
The global surgical package consists of preoperative services, surgical procedures, and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's

care. When more than one physician performs services that are included in the global surgical package, the total amount reimbursed for all physicians may not be higher than what would have been paid if a single physician provided all services.

Correct coding guidelines require that the same surgical procedure code (with the appropriate modifier) be used by each physician to identify the services provided when the components of a global surgical package are performed by different physicians.

Claims received with split-care modifiers after a global surgical claim has been paid will be denied.

When an assistant surgeon is used and/or multiple procedures are performed, assistant surgeon and/or multiple procedure rules and fee reductions apply.

Related Coding

Code	Description	Comments
Modifier 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.	Reimbursed at 70%
Modifier 55- Post-operative care only	When one physician or other qualified health care professional performed the postoperative management and another has performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number	Reimbursed at 20% • When postoperative management only care is rendered for a time frame which is less than the published postoperative global period, report modifier 52 (reduced services) in addition to modifier 55. This will reduce the calculated reimbursement for modifier 55 by 50% • When modifier 55 is appended to procedures that have zero post-operative care days the service will not be eligible for reimbursement.
Modifier 56- Pre-operative care only	When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may	Reimbursed at 10%

	be identified by adding modifier 56 to the usual procedure number	

Policy History

06/14/2023	Initial committee approval and effective 06/14/2023: Policy language removed from Global Surgical Package-Professional policy(C-08007) to create a new focused policy.

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2022

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Assistant at Surgery (Modifiers 80, 81, 82, AS) - Professional
Global Surgical Package - Professional
Global Surgical Package - Facility
Maternity Services - Professional
Modifier Rules -Professional
Multiple and Bilateral Surgery Processing - Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.