BlueCross BlueShield Minnesota

MEDICAID REIMBURSEMENT POLICY

Split Surgical Package

Active

Section: Surgery/Interventional Procedure
Policy Number: 024
Effective Date: 04/01/24

Description

This policy addresses the coding and reimbursement of the surgical package when a transfer of care occurs during the global period of a procedure.

Definitions

Global Period: the time period during which all necessary services normally furnished by a physician before, during and after a surgical procedure are included in the reimbursement for the procedure performed. Refer to *Medicaid Surgery/Interventional Procedure – 007 Global Surgical Package Reimbursement Policy* for more information.

Policy Statement

The surgical package includes all services normally provided by the surgeon, or other physician or qualified health care professional (QHP) during the preoperative, intraoperative, and postoperative period of a procedure. A split surgical package occurs when:

- Physicians agree on a transfer of care during the Global Period of a procedure with a 10 or 90 day global period and
- One or more components of the surgical package are provided by a physician or QHP of a different specialty or from a different practice than the physician that performed the procedure.

Transfer of Care

When physicians agree on a transfer of care, it must be documented in the patient's medical record, and the date on which care was relinquished or assumed must be shown in the remarks field of the claim.

Modifiers

The appropriate modifier (54, 55) specific to the surgical package component that is being billed must be appended to the surgical procedure code. Services billed with modifiers 54 or 55 must be billed with the same surgical CPT code and the date of service the surgical procedure was performed.

Consistent with the Centers for Medicare and Medicaid Services (CMS), Blue Cross and Blue Shield of Minnesota (Blue Cross) considers the surgical service to include preoperative management. Therefore, preoperative care (modifier 56) is not separately reimbursed.

Modifiers	
54	Surgical Care Only • Append modifier 54 to the surgical procedure code when one physician performs the intraoperative portion of a surgical procedure while another physician(s) of a different specialty or from a different practice provides the postoperative management. • Modifier 54 does not apply to assistant at surgery services or an ambulatory surgery center's facility fees. • Procedures with a global day assignment of 10 or 90 that are billed with modifier 54 will be reimbursed at 80 percent of the approved allowance. **Note:** The surgical procedure should be billed globally (no modifier) if the pre-, intra-, and postoperative services are rendered by the same physician or other providers in the same group and same specialty.
55	Postoperative Management Only • Append modifier 55 to the surgical procedure code when postoperative services are provided by a different physician (i.e., different specialty and/or group practice). • Modifier 55 does not apply to assistant at surgery services or an ambulatory surgery center's facility fees. • Postoperative services are billed only once and include all visits within the designated period. Thus, only one payment will be made for the post-op care. • Do not submit separate, itemized services for uncomplicated surgical follow-up. • Procedures with a global day assignment of 10 or 90 that are billed with modifier 55 will be reimbursed at 20 percent of the approved allowance. • If more than one physician bills for the postoperative care, reimbursement will be divided between the practitioners based on the number of days each practitioner was responsible for the patient's post-op care.
56	Preoperative Management Only • 0% reimbursement

A split surgical package will be reimbursed up to, but not to exceed,100% of the total global surgical allowed amount.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	54 55 56
ICD-10 Diagnosis:	N/A
ICD-10 Procedure:	N/A
CPT/HCPCS:	All surgical codes
Revenue Codes:	N/A

Resources

Current Procedural Terminology (CPT ®)
Medicare Claims Processing Manual, Chapter 12, Section 40.2
Medicare Learning Network, MLN907166

Policy History

01/23/2024	Initial Committee Approval