Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Split-Care Surgical Modifiers		
Effective Date: **08/01/2016**	Committee Approval Obtained: **08/01/2016**	Section: **Coding**

*****The most current version of the Reimbursement Policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid/Medicare. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup 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 CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Amerigroup may:

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

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however,

Amerigroup strives to minimize these variations.
Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup allows reimbursement of **surgical codes** appended with "split-care modifiers" unless provider, state, federal or CMS 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. Unless otherwise noted in Exhibit A, Amerigroup will use the following standard: • Modifier 54 (surgical care only): 70 percent • Modifier 55 (postoperative management only): 20 percent • Modifier 56 (preoperative management only): 10 percent 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 have 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.
Exemptions	• Amerigroup Kansas, Inc., in accordance with Kansas Medical Assistance Program (KMAP), reimburses services appended with Modifier 54 and Modifier 55 the appropriate percentage as indicated in the MPFSDB (Medicare Physician Fee Schedule Data Base). For those procedures that have surgical indicator "YYY" and are assigned a global period of 010 or 090 days, reimbursement of Modifier 54 is 80 percent and Modifier 55 is 10 percent.
History	• Effective 10/05/17: Entered California Medicaid • Effective 10/01/17: Entered Washington, D.C.; Exhibit updated • Effective 10/01/17: Entered Medicare Medicaid Program (MMP) • Approved and effective 09/29/16: KS exemption added and Exhibit updated • Biennial review approved and effective 08/01/16: Exhibit A:

	Split-Care Surgical Modifiers Reimbursement grid added; Definition section updated
	• Effective 04/01/16: Entered Iowa
	• Effective 03/01/16: South Carolina exemption added; Entered South Carolina
	• Effective 01/01/16: New York FIDA exemption removed; Exited New York FIDA
	• Effective 12/31/15: Exited Florida Medicare: Effective 03/01/15: Entered West Virginia
	• Effective 02/01/15: Indiana exemption added (updated 01/21/15); Entered Indiana
	• Updated 01/26/15: Medicare Advantage exemption updated
	• Effective 12/31/14: Exited Maryland Medicare: Update due to regulatory directive (committee approval not required in accordance with Reimbursement Policy Program Guidelines): Kansas exemption updated 09/22/14
	• Effective 07/01/14: Wisconsin exemption added (updated 07/01/14); Entered Wisconsin
	• Biennial review approved 05/12/14: Policy language updated; New York exemption added
	• Effective 04/07/14: Medicare Advantage Exemption updated
	• Effective 04/01/14: Entered Virginia MMP
	• Effective 01/01/14: Entered Kentucky
	• Effective 12/31/13: Exited New Mexico
	• Effective 07/01/13: Exited Ohio
	• Review approved 03/14/13 and effective 03/14/13 : Washington, Kansas, Nevada and Medicare Advantage exemptions added; policy template updated 03/14/13
	• Biennial review approved 11/07/11 and effective 03/16/12: Policy adapted from Modifier 54: Surgical Care Only (#06-012), Modifier 55: Postoperative Management Only (#06-013) and Modifier 56: Preoperative Management Only (#06-014) policies; Florida and Maryland exemption added; definitions section updated; reference materials updated to indicate 2010 editions; policy template updated
	• Initial committee approval 05/04/06
	  ○ Modifier 54: Surgical Care Only effective: 10/01/06
	  ○ Modifier 55: Postoperative Management Only effective: 05/04/06
	  ○ Modifier 56: Preoperative Management Only effective: 05/04/06

References and	This policy has been developed through consideration of the

Research Materials	following: • CMS • State Medicaid • Amerigroup state contracts • Optum360 Learning: Understanding Modifiers, 2016 Edition
Definitions	• **Modifier 54:** 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. • **Modifier 55:** 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. • **Modifier 56:** 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 be identified by adding modifier 56 to the usual procedure number. • **Reimbursement Policy Definitions**
Related Policies	• Assistant at Surgery (Modifiers 80/81/82/AS) • Code and Clinical Editing Guidelines • Modifier Usage • Multiple and Bilateral Surgery: Professional and Facility Reimbursement
Related Materials	• None

Exhibit A: Split-Care Surgical Modifiers Reimbursement

Market	Split-Care Modifier Usage			
	54	**55**	**56**	**Notes**
D.C.	70%	20%	10%	
Florida	50%	30%	20%	
Georgia	GBD Standard	GBD Standard	GBD Standard	
Kansas	80%	10%	Not payable	These percentages are for those procedures that have surgical indicator “YYY” and are assigned a global period of 010 or 090 days. Please see exemption section for more information.
Maryland	80%	GBD Standard	Not payable	
New Jersey	GBD Standard	GBD Standard	GBD Standard	
Tennessee	GBD Standard	GBD Standard	GBD Standard	
Texas	GBD Standard	GBD Standard	GBD Standard	
Washington	80%	10%]	GBD Standard	