	Reimbursement Policy	
Subject: Split-Care Surgical Modifiers		
Effective Date: **10/01/17**	Committee Approval Obtained: **04/03/17**	Section: **Coding**

*****The most current version of our 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/TX.*****

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) if the service is covered under the Amerigroup STAR+PLUS MMP 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 STAR+PLUS MMP may:

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

Amerigroup STAR+PLUS MMP reimbursement policies for Amerigroup STAR-PLUS MMP 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup STAR+PLUS MMP strives to minimize these variations.

Amerigroup STAR+PLUS MMP 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 STAR+PLUS MMP 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:

	• Modifier 54 (surgical care only): based on Medicare fee-for-service allowance • Modifier 55 (postoperative management only): based on Medicare fee-for-service allowance • Does not allow separate reimbursement of Modifier 56 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.

Exemption	• Amerigroup Texas, Inc. and Amerigroup Insurance Company allow reimbursement of surgical codes appended with split-care modifiers; reimbursement is based on the following percentages:
	  ○ Modifier 54 (surgical care only): 70 percent
	  ○ Modifier 55 (postoperative management only): 20 percent
	  ○ Modifier 56 (preoperative management only): 10 percent

History	• Initial review approved **04/03/17** and effective **10/01/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS policies • Texas Health and Human Services Commission (HHSC) • Amerigroup STAR+PLUS MMP contract with HHSC • Optum Learning: Understanding Modifiers, 2014 edition
Definitions	• **Modifier 54:** used to indicate that a surgeon performed only the surgical component of a global surgical package (i.e., another physician provided postoperative care) • **Modifier 55:** used to indicate that a physician other than the surgeon performed only the postoperative management component of a global surgical package

	• **General Reimbursement Policy Definitions**
Related Policies	• Assistant at Surgery (Modifiers 80/81/82/AS) • Clinical Code Editing Guidelines • Modifier Usage • Multiple and Bilateral Surgery: Professional and Facility Reimbursement
Related Materials	• None