Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHPlus), and Essential Plan members. Please note, this information is specific to the MMC, HARP, CHPlus, and Essential Plan programs only.

Reimbursement Policy	
Subject: **Split-Care Surgical Modifiers**	
Policy Number: **G-11005**	Policy Section: **Coding**
Last Approval Date: **01/30/2023**	Effective Date: **05/01/2020**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **providerpublic.mybcbswny.com**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Highmark BCBS covered the service for the 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, Highmark BCBS may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Highmark

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BCBS strives 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

Highmark BCBS 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.

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 among the 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 exceed what would have been paid if one physician had provided all services.

Correct coding guidelines require that each physician use the same surgical procedure code (with the appropriate modifier) 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 healthcare 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 healthcare	Reimbursed at 20%

	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- Pre-operative care only	When one physician or other qualified healthcare 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.	Reimbursed at 10%

Policy History	
01/30/2023	Review approved: no changes
07/13/2020	Review approved: no changes
10/03/2018	Review approved 10/03/2018 and effective 05/01/2020: Split-care modifier percentages updated
08/01/2016	Initial approval 08/01/2016 and effective 01/01/2017

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State Medicaid
- State contract

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

- Assistant at Surgery (Modifiers 80/81/82/AS)
- Code and Clinical Editing Guidelines
- Modifier Usage
- Multiple and Bilateral Surgery: Professional and Facility Reimbursement