UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
Policy Number 2023R9035A

Split Surgical Package Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

Application

This reimbursement policy applies to all Medicare Advantage products and for services reported using the 1500 Health Insurance Claim Form (a/k/a CMS 1500) or its electronic equivalent or its successor form. This policy applies to all network physicians and other qualified health care professionals.

Policy

Overview

The Surgical Package consists of the preoperative, surgical, and postoperative services. A Split Surgical Package occurs when the postoperative care is rendered by a physician other than the physician performing the surgical service. For example, one physician performs the surgical service only and turns the postoperative management over to a separate physician (not within the Same Group Practice).

Reimbursement Guidelines

Consistent with the Centers for Medicare and Medicaid Services (CMS), UnitedHealthcare Medicare Advantage considers the surgical care rendered by the Same Group Physician and/or Other Qualified Health Care Professional to include preoperative management. Accordingly, in Split Surgical Package situations, the preoperative and surgical care portions of the Surgical Package are combined by UnitedHealthcare Medicare Advantage in the reimbursement of surgical codes appended with modifier 54. Preoperative care is not reimbursed separately. Postoperative care management may be reimbursed separately when a physician or other health care professional who is not within the Same Group Practice as the operating physician provides the postoperative care as denoted by submission of the surgical code appended with modifier 55. Split global-care billing does not apply to procedure codes with a zero-day post-operative period.

Split Surgical Package situations will be reimbursed not to exceed 100% of the total global surgical allowable amount, and are reimbursable at the percentages indicated:

Modifier	Percentage
54	80%
55	20%
56	0%
TOTAL:	100%

More than one physician may furnish services included in the global Surgical Package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the post-operative, post-discharge care is split among two or more physicians where the physicians agree on the transfer of care. When more than one physician furnishes services that are included in the global Surgical Package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provided all services, except where stated policies allow for higher payment. For instance, when the surgeon furnishes only the surgery and a physician other than the surgeon furnishes pre-operative and post-operative inpatient care, resulting in a combined payment that is higher than the global allowed amount. The surgeon and the physician furnishing the post-operative care must keep a copy of the written transfer agreement in the beneficiary's medical record. Where a transfer of care does not occur, the services of another physician may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case.

Using Modifiers "-54" and "-55"
Where physicians agree on the transfer of care during the global period, services will be distinguished by the use of the appropriate modifier.

For global surgery services billed with modifiers "-54" or "-55," the same CPT code must be billed. The same date of service and surgical procedure code should be reported on the bill for the surgical care only and post-operative care only. The date of service is the date the surgical procedure was furnished.

Modifier "-54" indicates that the surgeon is relinquishing all or part of the post-operative care to a physician.

- Modifier "-54" does not apply to assistant at surgery services.
- Modifier "-54" does not apply to an ASC's facility fees.

The physician, other than the surgeon, who furnishes post-operative management services, bills with modifier "-55."

- Use modifier "-55" with the CPT code for global periods of 10 or 90 days.
- Report the date of surgery as the date of service and indicate the date care was relinquished or assumed. Physicians must keep copies of the written transfer agreement in beneficiary's medical record.
- The receiving physician must provide at least one service before billing for any part of the post-operative care.
- This modifier is not appropriate for assistant at surgery services or for ASC's facility fees.

Definitions	
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group reporting the same Federal Tax Identification number.
Split Surgical Package	The surgical package consists of the preoperative, surgical and postoperative service. A split surgical package occurs when a component of the surgical package is rendered by a physician other than the physician performing the surgical service.
Surgical Package	A Surgical Package includes the following services in addition to the procedure: • Visits after the decision for a procedure is made beginning with the day before the procedure for a major procedure and the day of the procedure for all others; • Services that are normally a usual and necessary part of a procedure; • Complications Following the Procedure - All additional medical or surgical services required during the postoperative period because of complications which do not require additional trips to the operating room; • Postoperative Visits - Follow-up visits during the postoperative period that are related to recovery; • Post-procedure Pain Management; • Supplies - Except for those identified as exclusions; and • Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Resources

www.cms.gov

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Medicare Claims Processing Manual - Chapter 04 - Part B Hospital (Including Inpatient Hospital Part B and OPPS) Section 250.17

Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners Sections: 40.2 and 40.4

Medicare Physician Fee Schedule PFS Relative Value Files - Intra operative and Post operative

The Medicare Learning Network (MLN Matters): MM7872

History

6/1/2023	Policy Version Change Policy Logo Updated Policy Template Updated History section: Entries prior to 6/1/2021 archived Resources section Updated
6/1/2021	Policy Version Change Removed code descriptions

	Updated template History section: Entries prior to 6/1/2019 archived
3/9/2016	New Policy