SPLIT SURGICAL PACKAGE POLICY

Policy Number: ADMINISTRATIVE 186.14 T0 **Effective Date**: December 1, 2019

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Related Policies

None

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

APPLICATION

This Reimbursement Policy applies to services reported using the UB-04 claim form, the 1500 Health Insurance Claim Form (a/k/a CMS-1500), or their electronic equivalents or their successor forms. This policy applies to all network and non-network providers, including hospitals, ambulatory surgical centers, physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

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).

For purposes of this policy, Same Group Physician and/or Other Qualified Health Care Professional includes all physicians and/or other qualified health care professionals of the same group reporting the same Federal Tax Identification number (TIN).

REIMBURSEMENT GUIDELINES

Consistent with the Centers for Medicare and Medicaid Services (CMS), Oxford 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 Oxford 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 qualified 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 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	Modifier Description	Percentage
54	Surgical Care Only (includes preoperative and surgical care management)	80%
55	Postoperative Management only	20%
56	Preoperative Management only	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:

- Surgical care only (modifier "-54"); or
- Post-operative management only (modifier "-55").

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.

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 service 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.

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Payment Policy Oversight Committee. [*2019R0106B*]

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.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
12/01/2019	• Replaced references to "Other Health Care Professional" with "Other *Qualified* Health Care Professional" **Reimbursement Guidelines** • Added language to indicate: ○ 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: ▪ Surgical care only (modifier "-54"); or ▪ Post-operative management only (modifier "-55") ○ 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

Date	Action/Description
	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 **Definitions** • Replaced term labeled "Same Group Physician and/or Other Health Care Professional, *Same Group Practice*" with "Same Group Physician and/or Other *Qualified* Health Care Professional" **Supporting Information** • Archived previous policy version ADMINISTRATIVE 186.13 T0