Anthem

	Reimbursement Policy

Subject: Split-Care Surgical Modifiers

Effective Date:	Committee Approval Obtained:	Section:
08/01/16	**10/03/18**	**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://mediproviders.anthem.com/wi**.*****

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield (Anthem) if the service is covered by a BadgerCare Plus 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 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, Anthem may:

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

Anthem 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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, Anthem strives to minimize these variations.

Anthem 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

Anthem allows reimbursement of **cataract 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): 80% for preoperative and minor surgery — 80% for preoperative care and major surgery
- Modifier 55 (postoperative management only): 20%

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	Anthem does not allow separate reimbursement for 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 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.
History	• Biennial review approved **10/03/18**: Policy template updated • Biennial review approved and effective **08/01/16**: Definition section updated • Initial approval and effective date **07/01/14**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts
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 • **General 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