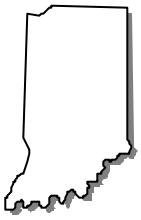
Indiana Health Coverage Programs



PROVIDER BULLETIN

BT200216 APRIL 18, 2002

To: **All Physician, Dental, Podiatry, and Optometric Providers**

Subject: **Split Billing of Global Surgery Postoperative Care Days**

Overview

Reimbursement for most surgical procedures is based on the global concept that includes three parts: preoperative management, intraoperative (surgical) care, and postoperative management. The Centers for Medicare and Medicaid Services (CMS) assigned a specific reimbursement percentage to each of the three global components. The percentage is used to calculate the allowed reimbursement for each component when the global care is split among multiple providers or when a return to surgery is necessary for a related procedure within the postoperative period.

Billing Percentages

Although there are three components, the Indiana Health Coverage Programs (IHCP) only recognizes split billing for two of the components, intraoperative and postoperative care. It is expected that the physician performing the intraoperative portion will perform the preoperative service. Therefore, the preoperative and intraoperative percentages are combined to calculate the total percentage associated with the intraoperative care. The components are identified with *modifier 54 – preoperative + intraoperative care*, and *modifier 55 – postoperative management*. Even though *modifier 56 – preoperative care only* exists, the IHCP does not recognize this as a valid modifier. If modifier 56 is billed, Indiana*AIM* denies the detail for modifier 56 and generates an invalid modifier message.

Postoperative Care Days

In addition to assigning a percentage to postoperative care, most surgical procedure codes include a definite number of postoperative care days in the global surgical package. The number of postoperative care days assigned to a particular procedure is

determined by the CMS. Surgical procedures can be assigned zero, 10, or 90 days of postoperative care depending upon the complexity and anticipated follow-up care needed after surgery. The number of days assigned to a given procedure is located on the *Medicare Physician Fee Schedule Relative Value* file. This file is available on the Internet at http://www.hcfa.gov/stats/pufiles.htm#rvu. Once the site is accessed, scroll down to the *National Physician Fee Schedule Relative Value* file and download the information.

Effective June 1, 2002, Indiana*AIM* has been modified to allow reimbursement of postoperative care split among multiple providers. Payment is based on the number of postoperative care days furnished by each provider, and are not to exceed the number of days assigned by the CMS.

> *Note: The split billing of global surgery services only applies to physician surgical services; not anesthesia services.*

Requirements for Split Care

The IHCP requires a written agreement when the global surgical procedure is split among multiple providers. The conditions are the same as those for Medicare and are illustrated as follows:

- Providers billing for split care must have a written agreement outlining the date care is to be turned over and the name of the provider receiving the patient.
- Agreement must become part of the patient's file.
- Agreement must be submitted with any review or hearing request about the split care payment.
- Modifier 54 must not be billed unless a written agreement exists.
- Physician must bill the appropriate current procedural terminology (CPT) code without modifier 54 or 55 if a written agreement does not exist.

Split Care Billing Procedures and Reimbursement Calculation

When the provider, who performed the actual surgery, also provides a portion of the postoperative care, the provider must bill the surgical procedure code with *modifier 54 – surgical care only,* and the detail line must indicate the actual date of surgery. Any postoperative care provided must be reported on a separate detail line. Postoperative care must be billed using the surgical procedure code with *modifier 55 – postoperative management only*. The dates of service must reflect the date care was assumed and relinquished and the units field must include the total number of postoperative days furnished. To ensure appropriate reimbursement when billing with modifier 55, the number of days within the date of service range must equal the

number of units (days) reported on the claim. For the purposes of defining postoperative care units, one unit is equal to one day of postoperative care.

> *Note: The postoperative period begins the day after surgery.*

When the provider who performed the surgery does not provide any postoperative care, the provider must bill the surgical procedure code with *modifier 54 - surgical care only*, and the actual date of the surgery. The provider who assumes postoperative management must bill the surgical procedure code with *modifier 55 – postoperative management only*. The date of service must reflect the date care was assumed and relinquished, and the units field must reflect the total number of postoperative care days provided. To ensure appropriate reimbursement when billing with modifier 55, the number of days within the date of service range must equal the number of units (days) reported on the claim. For the purposes of defining postoperative care units, one unit is equal to one day of postoperative care.

> *Note: The postoperative period begins the day after surgery.*

Postoperative management claims must not be submitted until the physician managing the postoperative care sees the patient for the first time.

Audits are in place to limit the number of units billed for postoperative care whether the procedure is a 10- or 90-day global procedure. Ten-day global surgeries allow 10 days or units of postoperative care; and 90-day global surgeries allow 90 days or units of postoperative care.

If a claim is billed with a detail that exceeds the number of allowed units, the entire detail systematically denies. It is the responsibility of the provider billing for postoperative care to correct any billing issues related to the number of units billed by each provider.

Following are two examples that define appropriate billing procedures for split care and show how reimbursement is calculated. The examples use procedure code 43030, a 90-day postoperative period, and allow a total of $460.48 for the global service.

Table 1.1 – Procedure Code 43030

Description	Percentage	Modifier
Preoperative percentage	9%	
Intraoperative percentage	+81%	
Total intraoperative percentage	90%	54
Postoperative percentage	10%	55
Total	100%	

Example 1

In this example, two different physicians split the postoperative care. Physician A performs the surgical procedure and manages the patient postoperatively for 60 days:

Table 1.2 – Billing Physician A

Physician A	From Date of Service	To Date of Service	Procedure Code	Modifier	Units Billed
Detail 1:	10/01/1999	10/01/1999	43030	54	1
Detail 2:	10/02/1999	11/30/1999	43030	55	60

Calculations are made as follows:

Detail 1 Global fee of $460.48 multiplied by .90 (9% preoperative percentage + 81% intraoperative percentage) multiplied by 1 unit billed equals $414.43

Detail 2 Global fee of $460.48 multiplied by .10 equals the total postoperative allowance of $46.048 divided by 90 (number of global days assigned) equals $0.5116 per day multiplied by 60 (number of postoperative days reported) equals $30.699 or $30.70.

Physician B performs the balance of the postoperative care for 30 days:

Table 1.3 – Billing Physician B

Physician B	From Date of Service	To Date of Service	Procedure Code	Modifier	Units Billed
Detail 1	12/01/1999	12/30/1999	43030	55	30

Calculations are made as follows:

Detail 1 Global fee of $460.48 multiplied by .10 equals the total postoperative allowance of $46.048 divided by 90 (number of global days assigned) equals $0.5116 per day multiplied by 30 (number of postoperative days reported) equals $15.348 or $15.35.

When only one provider is responsible for the surgery and all of the postoperative care, the provider must bill the surgical procedure, without modifier 54 or 55. The IHCP allowed amount in this case would be 100 percent of the resource-based relative value scale (RBRVS) fee. **Modifiers 54 and 55 are used only to split postoperative care between multiple providers.**

Example 2

In this example, the same provider bills for the surgery and all of the postoperative care. Physician A performs and bills for the surgical procedure and all of the postoperative care:

Table 1.4 – Billing Physician A

Physician A	From Date of Service	To Date of Service	Procedure Code	Modifier	Units Billed
Detail 1:	10/01/1999	10/01/1999	43030		1

Calculations are made as follows:

Detail 1 The global fee for procedure code 43030 is $460.48. Therefore, reimbursement for this service should be made at $460.48

Exceptions and Special Billing Considerations

- If more than one physician in the same group practice participates in a portion of a patient's care, included in a global surgery package, only the physician who performs the surgery can submit a bill. Split care modifiers are not applicable and the surgeon's claim must only include the surgical procedure. Although other physicians participated in the care, all are within the same group practice. There is no need to split the reimbursement because the physician group is reimbursed the global fee.
- If a transfer of care does not occur, occasional post-discharge services for a physician other than the surgeon are reported with the appropriate evaluation and management (E&M) code. Modifiers are not required.
- If the transfer of care occurs immediately after surgery, the physician who provides the postoperative care while the patient remains in the hospital bills using subsequent hospital care codes. Once the patient is released from the hospital, the physician responsible for postoperative care bills using the surgical procedure code with modifier 55. The surgeon should bill the appropriate surgical procedure code with modifier 54. This situation can occur when an itinerant (traveling) surgeon is used.
- If a physician provides follow-up services during the postoperative period for minor procedures performed in the emergency department, the physician must bill

the appropriate level of office visit code. The emergency department physician who performed the surgical service bills the surgical procedure code without a modifier.

- If the services of a physician, other than the surgeon, are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate E&M code and split care modifiers are not required on the claim. For example, a cardiologist may manage the underlying cardiovascular condition during the postoperative period for a cardiovascular procedure that was performed by a cardiothoracic surgeon.
- If a patient is returned to surgery for a related procedure during the postoperative period and billed using modifier 78, the IHCP-allowed amount is calculated by multiplying the RBRVS fee amount by the surgical care only (intraoperative) percentage on the Medicare fee schedule data base (MFSDB). In these situations, the preoperative percentage is not added to the intraoperative percentage for calculating the allowed amount described in the first example. In addition, a new postoperative period is not allowed for the related procedure. The number of postoperative days allowed following the return to surgery is equal to the number of postoperative days remaining from the original procedure.

Billing certain modifiers on the same detail is restricted as follows, to avoid processing issues:

- Modifier 54 (intraoperative) **cannot** be billed on the **same detail** as modifiers: 55, 78, 80, 81, 82, AA, P1 through P5, QJ, QK, QX, QZ, QO, QQ, X6, and W5 through W7 or the detail denies for an invalid modifier combination.
- Modifier 55 (postoperative) **cannot** be billed on the **same detail** as modifiers: 54, 78, 80, 81, 82, AA, P1 through P5, QJ, QK, QX, QZ, QO, QQ, X6, and W5 through W7 or the detail denies for an invalid modifier combination.