

SPLIT SURGICAL PACKAGE

File Name: split_surgical_package

Origination: 10/2021

Last Review: 12/2022

Next Review: 12/2023

Description

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 different physician or group practice than the physician / group practice performing the surgical service.

When one physician or other qualified health care professional performed a surgical procedure and another provider (not within the same group practice) performed the preoperative and/or postoperative management, the surgical component may be identified by adding modifier 54 to the usual procedure code.

When one physician or other qualified health care professional performed the postoperative management and another provider (not within the same group practice) performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure code.

When one physician or other qualified health care professional performed the preoperative care and evaluation and another provider (not within the same group practice) performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure code.

Claims may be processed according to same provider or same group practice. Same group practice is defined as a physician and/or other qualified health care professional of the same group and same specialty with the same Federal Tax ID number.

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) will reimburse components of the surgical package according to the criteria outlined in this policy.

Reimbursement Guidelines

Split surgical care modifiers 54, 55, and 56 are only valid with surgical procedure codes having a 10- or 90-day global period. All providers submitting split surgical care modifiers should use the same procedure code and use the actual surgery date as the date of service.

Services submitted with a 54 modifier will receive 70% of the allowed reimbursement.

Services submitted with a 55 modifier will receive 20% of the allowed reimbursement.

Services submitted with a 56 modifier will receive 10% of the allowed reimbursement.

Services appended with either a 54, 55, or 56 modifier will not be eligible for reimbursement when there is evidence that this service has been billed by another provider on the same date of service and paid at the

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global rate. Alternatively, global procedures will not be eligible for reimbursement when another provider has already billed that same procedure for the same date of service using modifiers 54, 55, or 56.

Service codes appended with modifier 55 or 56 will not be eligible for reimbursement when the same claim line is also appended with modifier 78, representing an unplanned return to the OR for a related procedure. For more information, please refer to the related “Unplanned Return to Surgery” policy.

Emergency specialty physicians performing surgical procedures in place of service 23 will receive 70% of the allowed reimbursement, with or without modifier 54. Emergency physicians who provide follow-up services for surgical procedures performed in emergency departments are encouraged to file the appropriate level of evaluation and management (E/M) code.

Rationale

In alignment with CMS and correct coding initiatives, Blue Cross NC will reduce reimbursement for services filed with modifier 54, 55, and 56.

Emergency physicians performing surgical procedures in place of service 23 do not render preoperative or postoperative management, therefore reimbursement is limited to the surgical component.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com.

Modifier	Description
Modifier 54	Surgical Care Only
Modifier 55	Postoperative Management Only
Modifier 56	Preoperative Management Only
Modifier 78	Unplanned Return to the Operating Room/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

Related policy

[Global Surgery](#)

[Unplanned Return to Surgery](#)

References

American Medical Association, *Current Procedural Terminology (CPT®)*

Centers for Medicare & Medicaid Services, Claims Processing Manual 100-04 [100-04 | CMS](#)



History

10/19/2021	New policy developed. Blue Cross NC will provide reimbursement for components of the surgical package according to the criteria outlined in this policy. Notification on 10/19/2021 for effective date 1/1/2022. (eel)
6/1/22	Language updated throughout policy. "Claims may be processed according to same provider or same group practice...." added to Description section. "All providers submitting split surgical care modifiers should use the same procedure code and use the actual surgery date as the date of service." added to Reimbursement Guidelines. Language related to services appended with 54, 55, or 56 billed on same day as global added to Reimbursement Guidelines. Language related to services appended with 55 or 56 and also 78 added to Reimbursement Guidelines. Medical Director approved. Notification on 3/31/2022 for effective date 6/1/2022. (eel)
12/31/2022	Routine policy review. Minor revisions only. (ckb)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.

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