JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.001
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	Subject **Split-Care Procedures**	*Revision Date*	07/05/2023
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This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords:

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I. ABOUT OUR REIMBURSEMENT POLICIES:

The most current version of the reimbursement policies can be found on hopkinsmedicine.org

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual". The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

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

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE:

JHHP will allow the reimbursement of split care surgical codes appended with modifiers 54, 55, 56 when used appropriately and in accordance with nationally accepted correct coding guidelines, unless provider, State, Federal or CMS contracts and/or requirements indicate otherwise.

III. POLICY STATMENT:

This policy applies to split care services submitted on UB-04 claim forms, CMS-1500 claim forms or their electronic equivalents. Each line of business possesses its own unique contract and guidelines which, for benefit and payment purposes, should be consulted first to know what benefits are available for coverage.

IV. SPLIT–CARE MODIFIERS (–54, –55 and –56) BILLING GUIDELINES

1. All claims must be submitted with the appropriate modifiers.
2. Providers must adequately document any service or procedure in the medical record and maintain records as necessary to fully document the services provided.
3. It is the policy of JHHP to consider reimbursement based on a percentage of the fee schedule, contracted, or negotiated rate (allowed amount) for the surgical procedure. The percentage will not exceed 100% of the total global surgical allowed amount and is determined by which modifier is appended to the procedure code.
4. 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.
5. Correct coding guidelines require that the same surgical procedure code (with the appropriate modifier) must be used by each physician to identify the services provided when the components of a global surgical package are performed by different physicians.
6. JHHP will process claims on a first in/first out approach. Claims received with split-care modifiers after a global surgical claim have been paid will be denied.
7. When an assistant surgeon is used and/or multiple procedures are performed, assistant surgeon and/or multiple procedure rules and fee reductions apply.
   a. Refer to JHHP's Assistant-at-Surgery: Modifiers 80, 81, 82 or AS policy for additional information.
8. In accordance with CMS guidance, JHHP will not reimburse surgical services rendered by a practitioner who is unlicensed or if the practitioner is identified as a medical student healthcare provider (taxonomy code 390200000X) reported on the claim.

V. REIMBURSEMENT METHODOLOGY:

Split Care Modifier Reimbursement

Modifier	Description	Percentage (%)
54	Surgical Care Only	70%
55	Supporting documentation is required to establish medical necessity of two surgeons for the procedure.	20%

56	Co-Surgeon concept does not apply	10%
Total	---------->	100%

VI. EXCLUSIONS:

PPMCO: JHHP aligns with the Maryland Department of Health Provider Manual reimbursement guidelines and payment methodology for those providers who bill for surgical services.

USFHP: JHHP aligns with the TRICARE Manual reimbursement guidelines and payment methodology for those providers who bill for surgical services, in addition to the TRICARE NGPL.

VII. EXEMPTIONS

1. The following lines of business do not allow separate reimbursement for Modifier 56:
   - Hopkins Health Advantage
   - Priority Partners
2. Refer to JHHP's Non-Reimbursable Codes policy for non-covered services.
3. Refer to JHHP's Unlisted Codes policy.

VIII. CODES, TERM and DEFINITIONS:

Definition of Terms

Term	Definition
Accredited Practitioner/ Physician	For the purpose of this policy, refers to providers who are not an excluded, nor opt-out physician or practitioner, and who meet the criteria for participation outlined in the credentialing policy.
Assistant-at-Surgery/Assistant Surgeon	A physician or other qualified health care professional who is assisting the physician performing a surgical procedure.
Bilateral Procedure	A procedure which can be performed on both sides of the body during the same session.
Unilateral Procedure	Unilateral procedures are procedures performed on one side of the body.
Physician or Other Qualified Health Care Professional (OQHCP)	A Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN).
Split Care Surgical Package	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/or • 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.

Split Care Modifiers

Modifier	Definition
50	Bilateral procedure performed on both sides of the body.
54	Used to indicate that a surgeon performed only the surgical component of a global surgical package (i.e., another physician provides postoperative care).
55	Used to indicate that a physician other than the surgeon performed only the postoperative management component of a global surgical package.
56	Used to indicate that a physician other than the surgeon performed only the preoperative evaluation component of a global surgical package.

Medicare Physician Fee Schedule Database (MFSDB) Status Codes

Status	Definition

B	These codes, whether covered services or not, are ***always bundled*** into payment for other services they are incident to. If relative value units (RVUs) are shown on the fee schedule, they are **not** used for payment.
E	These codes are ***excluded*** from the MPFS by regulation.
I	These codes are not valid for Medicare purposes. To prompt payment, another code must be reported.
M	These codes are used for reporting only.
N	These codes are ***not*** covered by Medicare.
Q	These codes are used for reporting only.
X	These codes have been assigned PC/TC indicator 9 and are not considered physician services for MFSDB payment purposes.

IX. REFERENCES:

This policy has been developed through consideration of the following:

- CMS Physician Fee Schedule
- CPT® Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- JHHP Credentialing Policy PCR.002 - Criteria for Practitioner Participation
- Maryland Department of Health
- Medicare Claims Processing Manual Ch. 04
- Medicare Claims Processing Manual Ch. 12
- Medicare Claims Processing Manual Ch. 26
- Medicare Physician Fee Schedule PFS Relative Value Files – Intraoperative and Postoperative
- NCCI for Medicaid | CMS
- NCCI for Medicare | CMS
- TRICARE Reimbursement Manual

X. APPROVALS:

Date	Review/Revision	Reason For Modification	Approved By
6/28/23	Revision	• Policy Template Updated • Billing Guidelines Updated • Codes, Terms And Definition Section Updated • References Section Updated • Exclusion Section Updated	Reimbursement Policy Committee (RPC)