

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – The Centers for Medicare & Medicaid Services (CMS) has posted to the CMS website [43 new Frequently Asked Questions \(FAQs\)](#) related to MLN Matters® Article [MM7502](#), “Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatient: 3-Day Payment Window and the Impacts on Wholly Owned or Wholly Operated Physician Offices.” The new FAQs for the 3-Day (or 1-day) Payment Window policy as it pertains to physician practices are located in the Downloads section of the CMS [Physician Fee Schedule](#) web page and the [Hospital PPS](#) web page.

MLN Matters® Number: MM7872 **Revised**

Related Change Request (CR) #: CR7872

Related CR Release Date: October 26, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R2574CP

Implementation Date: January 7, 2013

Payment of Global Surgical Split-Care in a Method II Critical Access Hospital (CAH) Submitted with Modifier 54 and/or 55

Note: This article was revised on January 23, 2013, to reflect the revised CR7872 issued on October 28, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, non-physician practitioners, and Method II Critical Access Hospitals (CAHs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (A/B MACs)) for services rendered in Method II CAHs to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7872, which instructs Medicare contractors to implement the payment methodology for global surgical split care submitted on type of bill 85X with revenue codes 96X, 97X, or 98X with a modifier 54 (Surgical care only) and/or a Modifier 55 (Postoperative management only) for CAH Method II providers. There are no policy changes attached to CR7872, which simply applies the logic currently used when split global surgery services are billed

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on professional claims to those services when billed by a Method II CAH to an FI or MAC on type of bill 85X with revenue codes of 96X, 97X, or 98X. Please be sure your billing staffs are aware of this clarification.

Background

Physicians and non-physician practitioners billing on type of bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (Revenue Code (RC) 96X, 97X, or 98X) based on the Medicare Physician Fee Schedule (MPFS) supplemental file.

Occasionally, when more than one physician provides services included in the global surgical package, the physician who performs the surgical procedure may not always furnish the follow-up care. When this occurs, payment for the postoperative, post-discharge care is split between 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 provides all services (except where stated policies result in payment that is higher than the global allowed amount, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care).

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. CAH Method II providers may review the split global surgery pricing rules in "Medicare Claims Processing Manual," Chapter 12, Sections 40.1-40.5, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> on the CMS website.

CR7872 implements the above payment logic in the Fiscal Intermediary Shared System (FISS) for CAH Method II providers to mirror the logic historically applied to physicians and non-physician practitioners that bill their own services to the Medicare Multi-Carrier System (MCS).

When payments are reduced as a result of applying this global surgery payment logic, Medicare will reflect that on the remittance advice using claim adjustment reason code 59 (Processed based on the multiple or concurrent procedure rules.) and Group Code CO to denote contractual obligation.

Section 1834(g)(2)(B) of the Social Security Act (the Act) states that professional services included within outpatient CAH services must be paid at 115 percent of such amounts as would otherwise be paid under this part if such services were not included in the outpatient CAH services.

Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule (MPFS) to determine the surgical care only and postoperative percentages for a specific Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code. The MPFS is

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located at <http://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx> on the CMS website.

Additional Information

The official instruction CR7872, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2574CP.pdf> on the CMS website.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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