CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2574	**Date: October 26, 2012**
	Change Request 7872

Transmittal 2510, dated August 3, 2012 is being rescinded and replaced by transmittal 2574 dated October 26, 2012, chapter 4, section 250.16 of the Medicare Claim Processing Manual was changed to section 250.17 to add a new section. All other information remains the same.

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

I. SUMMARY OF CHANGES: This instruction implements the payment methodology for global surgical split care submitted with a modifier 54 and/or 55 for CAH Method II providers.

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: January 7, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	04/250.17/Payment of Global Surgical Split-Care in a Method II CAH Submitted with Modifier 54 and/or 55

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; contractor activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2574	Date: October 26, 2012	Change Request: 7872

Transmittal 2510, dated August 3, 2012 is being rescinded and replaced by transmittal 2574, dated October 26, 2012, chapter 4, section 250.16 of the Medicare Claim Processing Manual was changed to section 250.17 to add a new section. All other information remains the same.

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

Effective Date: **January 01, 2013**
Implementation Date: **January 07, 2013**

I. GENERAL INFORMATION

A. 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.

There are occasions when more than one physician provides services included in the global surgical package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. 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, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global allowed amount).

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 Pub. 100-04, Chapter 12, Section 40.

This instruction 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 Multi-Carrier System (MCS).

B. Policy: Section 1834(g)(2)(B) of the Social Security Act (the Act) states that professional services included within outpatient CAH services shall be paid 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 MPFS to determine the surgical care only and postoperative percentages for a specific HCPCS/CPT code. The MPFS is located at: http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp . The fiscal intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs) have access to the payment policy indicators via the Physician Fee Schedule Payment Policy Indicator File in the FISS.

NOTE: There are no policy changes attached to the change in this manual section. It was updated for clarification purposes only.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7872.1	Contractors shall apply global surgery logic, after any multiple surgery logic, to TOB 85X with a revenue codes 96X, 97X and/or 98X , surgical CPT codes (10000-69999) that contain one or both of the following modifiers: 54 – Surgical Care Only 55- Postoperative Management Only						X				
7872.2	Contractors shall apply the global surgery logic using the Payment Policy Indicator file.						X				
7872.2.1	For surgical CPT codes containing modifier 54, contractors shall add the percentage from the preoperative percentage (modifier 56) field to the Intra-operative percentage (Modifier 54) field on the Payment Policy Indicator File.						X				
7872.2.1.1	Contractors shall multiply the lesser of the fee amount or the provider submitted charges by the percentage calculated in 7872.2.1						X				
7872.2.2	For surgical CPT codes containing modifier 55, contractors shall multiply the lesser of the fee amount or the provider submitted charges by the percentage identified in the Postoperative percentage (modifier 55) field on the Payment Policy Indicator File.						X				
7872.3	Contractors shall use the RED indicator field on claim page 30 to identify services that have received the global reduction.						X				
7872.4	Contractors shall apply the deductible and coinsurance based on the allowable amount.						X				
7872.5	Contractors shall continue to apply the 115% add on after the deductible and coinsurance.						X				
7872.6	Contractors shall use the following claim adjustment reason code for reduced global surgical services. **59** - Processed based on the multiple or concurrent procedure rules. (Contractors shall use the group code "CO" contractual obligation, on the remittance advice).	X		X			X				
7872.7	Contractors shall use the following message on the	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Medicare Summary Notice for claims for which global MPFS methodology was applied: 30.1 The approved amount is based on a special payment method. OR 30.1 La cantidad aprobada está basada en un método especial de pago.										
7872.8	Contractors shall not search for and adjust claims that have been paid prior to the implementation date. However, contractors shall adjust claims brought to their attention.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7872.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:
CR6013	Physician Fee Schedule payment Policy Indictor File Record Layout for Use in Processing Method II Critical Access Hospital (CAH) Claims for Professional Services.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Cindy Pitts at Cindy.Pitts@cms.hhs.gov or Jason Kerr at Jason.Kerr@cms.hhs.gov

Post-Implementation Contact(s):
Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(*Rev. 2574, Issued: 10-26-12*)

250.17 – Payment of Global Surgical Split Care in a Method II CAH Submitted with Modifier 54 and/or 55

(*Rev.2574 , Issued:10-26-12 , Effective:01-01-13 , Implementation:01-07-13*)

Global surgical procedures rendered by a physician that has reassigned their billing rights to a CAH Method II provider is payable by Medicare only when billed on an 85x type of bill (TOB) with revenue code (RC) 096x, 97x, and/or 98x and modifier 54 (surgical care only) and/or 55 (postoperative management only).
There are occasions when more than one physician provides services included in the global surgical period, i.e., when the physician who performs the surgical procedure does not furnish the follow-up care. If this occurs, payment for the postoperative or post-discharge care should be split between the physicians when they 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, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative care, result in payment that is higher than the global allowed amount).

CAH Method II providers may review the Global Surgical pricing rules in Pub. 100-04, Chapter 12, sections 40.1-40.5