moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM030
Policy Title:	Modifiers 54, 55, and 56 – Split Surgical Care		
Section:	Modifiers	Subsection:	Surgery

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☐ CMS1450/UB (or the electronic equivalent or successor forms) This policy applies to professional providers only. The global surgery package payment concept does not apply to facilities.
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	7/28/2004	Initially Published:	9/20/2013
Last Updated:	7/10/2024	Last Reviewed:	7/10/2024

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

Last Update Effective Date for Texas:	7/10/2024

Reimbursement Guidelines

A. General

When components of a global surgical procedure are furnished by different providers each provider is expected to report only the service they performed and identify that service with the appropriate modifier and with the surgery date listed as the date of service (*CMS*[1]), in accordance with correct coding guidelines. Indicate elsewhere on the claim the date care was relinquished or assumed. (CMS[2]) Where a transfer of postoperative care occurs, the receiving physician providing the postoperative follow-up care may not bill for any part of the global services until after he/she has seen the patient for the first postoperative visit/service. (*CMS*[1])

1. Modifier 54 indicates that the surgeon is relinquishing all of, or part of, the postoperative care to another physician. (CMS[2])

2. Modifier 55 is billed by the receiving physician, other than the surgeon, who accepts the transfer of care and furnishes postoperative management services.

3. If the surgeon was providing the entire global surgical package personally, the services would be reported as a single claim with the surgical procedure code and the date of the procedure. This claim would include all the postoperative care for the entire global period (e.g., 10 days or 90 days). When postoperative care is relinquished to another provider, the two claims for both providers will both be submitted as if the billing provider performed the surgical procedure. Only the modifier appended will be different to distinguish which portion of the global surgical package each billing provider has performed.

    a. Procedure code - Both the surgeon and physician providing post-operative management will report the same surgical code with their respective modifiers appended.

    b. Date of service - Both claims are reported with the date of the surgical procedure as the date of service.

    c. It is not appropriate to report each postoperative care visit with evaluation and management visit codes and modifier 55 appended. Modifier 55 is only appropriate to be used with a procedure code with global follow-up days of 10 or 90 days.

    d. Example of correct coding of split care claims:

Scenario	Date of service	Procedure code	Units
Surgeon's claim, Dr. Baker	10/21/2020	66982-54	1
Postoperative Management physician's claim, Dr. Campbell	10/21/2020	66982-55	1

4. A surgeon may not report both modifier 54 and modifier 55 for the same surgical procedure. The use of modifier 54 indicates the surgeon has transferred postoperative care (partial or total) to another provider, and the surgical code with modifier 55 appended will be billed by the receiving provider to whom the postoperative care was transferred.

5. Modifier 56 indicates that a physician or qualified health care professional other than the surgeon performed the preoperative care and evaluation prior to surgery.

B. Pricing Adjustments

1. For claims processed prior to July 1, 2018, modifiers 54 and 55 are reimbursed as follows:
    a. Modifier 54 at 80% of fee schedule.
    b. Modifier 55 at 20% of fee schedule.

2. For claims processed on or after July 1, 2018, modifiers 54, 55, and 56 are reimbursed as follows:

    a. For Medicare Advantage claims, participating providers:

Modifier 54:	70% of fee schedule global allowance
Modifier 55:	20% of fee schedule global allowance
Modifier 56:	10% of fee schedule global allowance

b. For Medicare Advantage claims, out-of-network providers:

Modifier 54:	Intra-operative portion of the global allowance
Modifier 55:	Post-operative portion of the global allowance
Modifier 56:	Pre-operative portion of the global allowance

c. For Medicaid claims:

Modifier 54:	70% of fee schedule global allowance
Modifier 55:	20% of fee schedule global allowance
Modifier 56:	10% of fee schedule global allowance

d. For Commercial claims:

Modifier 54:	70% of fee schedule global allowance
Modifier 55:	20% of fee schedule global allowance
Modifier 56:	10% of fee schedule global allowance

C. Valid procedure code/split care modifier combinations

'Split-care' modifiers 54, 55, and 56 are only valid with surgical procedure codes having a 10- or 90-day global period.

D. Invalid procedure code/split care modifier combinations

1. Modifiers 54, 55, and 56 are not considered valid for obstetric care procedure codes, as specific codes already exist to identify when more than one provider provides antepartum, delivery, and postpartum care.
2. Modifiers 54, 55, and 56 (aka split global-care billing) do not apply to procedure codes with a 0-day postoperative period. (CMS[2])
3. Modifiers 54, 55, and 56 are not considered valid for E/M, anesthesia, radiology, laboratory, medicine, or ambulance procedure codes, or any non-surgical HCPCS code.
4. Modifiers 54, 55, and 56 are not considered valid for provider types to which the global surgery concept and a postoperative care global period do not apply:
    a. Assistant surgeons
    b. Ambulatory Surgery Centers
    c. Outpatient Hospitals
    d. Inpatient Hospitals
5. These invalid procedure code/modifier combinations will be denied to provider write-off.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation	Definition
AMA	American Medical Association
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DRG	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
MPFSDB	(National) Medicare Physician Fee Schedule Database (aka RVU file)
NCCI	National Correct Coding Initiative (aka "CCI")
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	Relative Value Unit
UB	Uniform Bill

Definition of Terms

Term	Definition
Global surgery allowance	A single package allowable fee for the surgery and all of the usual pre-and post-operative care.
Global surgery package	All related care to the surgery for a specified period of time before and after the surgery, as defined by CMS. Definitions for the global surgery package may be found in the CMS NCCI Policy Manual, chapter 1, and in the CPT book at the beginning of the surgical section.
Split Care Split Surgical Care	When a physician from one group practice performs the actual surgical procedure, and the care is transferred to a physician in a different group practice for the postoperative care. Either physician can perform the pre-surgical care, depending upon the individual case circumstances and the agreement between the physicians involved.

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier 54	**Surgical Care Only:** When 1 (one) physician or other qualified heath care professional performs a surgical procedure and another provider preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.
Modifier 55	**Postoperative Management Only:** When 1 (one) physician or other qualified heath care professional performed postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

Modifier	Modifier Description & Definition
Modifier 56	**Preoperative Management Only:** When 1 (one) physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"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 provided all services, except where stated policies allow for higher payment. For instance, when the surgeon furnishes only the surgery and a physician other than the surgeon furnishes pre-operative and post-operative inpatient care, the resulting combined payment may not exceed the global allowed amount." (*CMS*[2])

"Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier." (*CMS*[1])

"Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary's medical record. Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service." (*CMS*[1])

"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." (*CMS*[2])

"Where physicians agree on the transfer of care during the global period, the following modifiers are used:

- "-54" for surgical care only; or
- "-55" for postoperative management only.

Both the bill for the surgical care only and the bill for the postoperative care only**, will contain the same date of service and the same surgical procedure code**, with the services distinguished by the use of the appropriate modifier." (*CMS*[1]) (emphasis added)

"The physician, other than the surgeon, who furnishes post-operative management services, bills with modifier "-55."

- Use modifier "-55" with the CPT procedure code for global periods of 10 or 90 days.
- Report the date of surgery as the date of service and indicate the date care was relinquished or assumed. Physicians must keep copies of the written transfer agreement in the beneficiary's medical record.
- The receiving physician must provide at least one service before billing for any part of the post- operative care.

- This modifier is not appropriate for assistant-at-surgery services or for ASC's facility fees." (CMS[2])

Exception: Minor procedures in the Emergency Department
"Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier." (*CMS*[1])

Cross References

A. "Global Surgery Package for Professional Claims." Moda Health Reimbursement Policy Manual, RPM011.
B. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.
C. "Maternity Care." Moda Health Reimbursement Policy Manual, RPM020.

References & Resources

1. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 40, 40.1, 40.2, and 40.4.
2. CMS. "Global Surgery Booklet." (aka Global Surgery Fact Sheet). Medicare Learning Network, 2011. July 8, 2013. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf .

Background Information

Split Surgical Care
There are occasions when more than one physician may furnish aspects of the services included in the global surgical package. When different physicians of a group practice participate in the care of the surgical patient, the group practice bills for the entire global surgical package. The physician who performs the surgery is reported as the performing physician. The other surgeons from the group are compensated for their participation in accordance with the group practice's internal procedures and agreements.

However, it may be the case that one physician performs the surgical procedure and another physician from a different group practice furnishes the postoperative follow-up care. This may occur due to the distance from home a patient traveled for the surgical procedure, the type of procedure or practice, or for other reasons. In these cases, the physicians involved agree on the transfer of care and must keep documentation of the agreement and the date the transfer of care occurred. Special billing rules apply.

When the global surgery care is transferred from one physician to another in this manner, modifiers 54, 55, and 56 are designated for use to identify which physician performed the components of the global surgical package. Modifiers 54, 55, and 56 are referred to as "split care modifiers."

Definition, Purpose, and Use of Billing Modifiers

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g., T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
7/10/2024	Formatting updates. No policy changes.
8/9/2023	Formatting updates. No policy changes.
7/13/2022	Added 8 Acronyms & one Definition of Terms. Formatting updates. No policy changes.
9/20/2013	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
7/28/2004	Original Effective Date (with or without formal documentation). Policy based on CMS global surgery/split care policy. (CMS[1, 2])