Modifiers 54, 55, and 56 – Split Surgical Care

Last Updated: 10/30/2026 **Last Reviewed:** 11/19/2026 **Originally Effective:** 7/28/2004
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No
If yes, Texas Last Update Effective Date: n/a **Policy #: RPM030**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any
Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** All

Reimbursement Guidelines

A. General

Split surgical care occurs when different providers furnish the preoperative, intraoperative, or postoperative components of a global surgical procedure. Most often, another provider handles the post-discharge care because of distance to the surgeon's office. Each provider should report only the portion of care personally performed. Split care modifiers identify that portion of the global surgery package.

B. Surgical Transfer of Care Billing and Coding

1. Transfers of care may be formal and documented or informal and not documented but expected.
   a. A formal transfer of care is documented in a letter or annotation in the discharge summary, hospital record, or Ambulatory Surgical Center (ASC) record." [4]
   b. An informal transfer of care is not documented as described above but is expected[2] and understood by the providers and the patient.

2. When a formal transfer of care occurs:
   a. All providers are required to:
      i. Bill the same global surgery procedure code and append the transfer of care modifier for the portion provided (modifier 54, 55, or 56).
      ii. List the surgery date as the date of service[1], consistent with split surgical care coding guidelines.
      iii. Indicate on the claim the date care was relinquished or assumed. Use the remarks field/free text segment on the claim form/format. [1]
      iv. 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. [1, 2]
   b. The receiving physician may bill global follow-up services only after providing at least one postoperative visit or service.[1, 2]
   c. Exceptions:
      i. When the surgeon transfers care immediately after surgery, including in-hospital postoperative care:
         1) To one physician who assumes care for the entire postoperative period, the physician assuming care bills the surgical code with modifier 55. The surgeon bills the surgical code with modifier 54.
         2) To a physician in a different group (TIN) than the surgeon and other than the one who will provide postoperative care after discharge:
            a) The physician providing inpatient postoperative care bills using subsequent hospital care codes for the inpatient hospital care.
            b) The physician providing the after-discharge postoperative care bills the surgical code with both modifier 55 and modifier 52.

ii. When the surgeon and the practitioner assuming care share the postoperative care approximately evenly, as in the following example scenario:

> An orthopedic surgeon performs open treatment of a tibial shaft fracture (27759). The partial postoperative care (modifier 55) is provided by the surgeon for the initial 45 days (March 10 - April 23) and is then turned over to another physician for the remaining 45 days (April 24 - June 7). [6]

The care is billed as follows:

1) The surgeon bills the surgical code with modifier 54 on one line and the surgical code with modifiers 55 and 52 on a second line.
2) The practitioner providing the second half of the postoperative care bills the surgical code with modifiers 55 and 52.

3. When an informal or non-documented transfer of care occurs:
   a. For all 90-day global surgical packages, the surgeon must append modifier 54 when they do not intend to provide postoperative care after discharge.
   b. For a practitioner in a different group (TIN) than the surgeon who provides an occasional post-discharge visit:
      i. Bill the appropriate new or established patient office/outpatient evaluation and management code on the visit date.
      ii. Bill add-on HCPCS code G0559 at the first visit after surgery. G0559 may be billed only once per 90-day period[3] and covers the additional one-time resources required for post-operative follow up, including:
         1) Reviewing surgical notes.
         2) Researching the surgical procedure and potential complications.
         3) Evaluating and physically examining the patient.
         4) Communicating with the surgeon.

C. 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

D. 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. [1, 5]

E. Invalid procedure code/split care modifier combinations

1. Modifiers 54, 55, and 56 are invalid for obstetric care codes because specific codes identify care divided among providers for 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. [2, 5]
3. Modifiers 54, 55, and 56 are invalid for E/M, anesthesia, radiology, laboratory, medicine, ambulance, and other 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

These invalid procedure code/modifier combinations will be denied to provider write-off.

Definitions

Acronyms/Abbreviations

Acronym	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
TAC	Texas Administrative Code
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.

Term	Definition
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.

Procedure Codes

Code	Code Definition
G0559	Post-operative care services provided by a practitioner other than the one who did the surgical procedure (or another practitioner in the same group practice)

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 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.

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Global Surgery Package for Professional Claims." Moda Health Reimbursement Policy Manual, RPM011.
C. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.
D. "Maternity Care." Moda Health Reimbursement Policy Manual, RPM020-A.

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, MLN907166. Last updated November 2024; Last accessed December 5, 2024. https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf .
3. CMS. "Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies." Page 740 of 3088. Last accessed December 6, 2024. https://public-inspection.federalregister.gov/2024-25382.pdf .
4. CMS. "Definition of a Global Surgical Package." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 40.1.B, 2nd bullet.
5. CMS. National Correct Coding Initiative Policy Manual. Chapter 1 General Correct Coding Policies, § D, "Evaluation and Management (E&M) Services," paragraph 5 re: minor surgical procedures.
6. Noridian Healthcare Solutions, Jurisdiction F. "Modifier 55; Claim Coding Example." Last updated May 09, 2025; Last accessed: October 30, 2026. https://med.noridianmedicare.com/web/jfb/topics/modifiers/55.

Policy History

Reminder: 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 current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
11/19/2026	Clarification added for various split-care scenarios. Resources updated. Minor rewording. No policy changes.
8/13/2025	Clarified Scope includes claim form CMS1450/UB for CAHs. Acronyms updated. Coding Guidelines & Sources section retired; see Resources for information. Formatting updates. No policy changes.
1/8/2025	Added G0559 for CY 2025. Updated Cross References and References & Resources. Formatting updates.
7/10/2024	Formatting updates. No policy changes.
8/9/2023	Formatting updates. No policy changes.
7/13/2022	Updated Acronyms & Definition of Terms. Policy History section added; entries prior to 2022 omitted (in archive storage). Formatting updates. No policy changes.
9/20/2013	Policy document 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. [1, 2]