Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

This policy applies to professional providers only. The global surgery package payment concept does not apply to facilities.

Reimbursement Guidelines

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\(^1\))

Modifier 54 indicates that the surgeon is relinquishing all of, or part of, the post-operative care to another physician. (CMS\(^2\))

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

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.

Modifier 56 indicates that a physician or qualified health care professional other than the surgeon performed the preoperative care and evaluation prior to surgery.
For claims processed prior to July 1, 2018, modifiers 54 and 55 are reimbursed as follows:

- Modifier 54 at 80% of fee schedule.
- Modifier 55 at 20% of fee schedule.

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

- 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

- 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

- For Medicaid/EOCCO 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

- 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

**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.

**Invalid procedure code/split care modifier combinations**

- 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.
- Modifiers 54, 55, and 56 (aka split global-care billing) do not apply to procedure codes with a 0-day postoperative period. (CMS²)
- 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.

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

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:
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 and 55 are designated for use to identify which physician performed the components of the global surgical package. Collectively, modifiers 54 and 55 may be 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.

Codes, Terms, and Definitions

Modifier Definitions:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Modifier Definition</th>
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<tbody>
<tr>
<td>Modifier 54</td>
<td>Surgical Care Only: When 1 (one) physician or other qualified health 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.</td>
</tr>
<tr>
<td>Modifier 55</td>
<td>Postoperative Management Only: When 1 (one) physician or other qualified health 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.</td>
</tr>
<tr>
<td>Modifier 56</td>
<td>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.</td>
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Acronyms Defined

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>MPFSDB</td>
<td>(National) Medicare Physician Fee Schedule Database (aka RVU file)</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>RVU</td>
<td>Relative Value Unit</td>
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**Definition of Terms**

<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Global surgery allowance</td>
<td>A single package allowable fee for the surgery and all of the usual pre-and post-operative care.</td>
</tr>
<tr>
<td>Global surgery package</td>
<td>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.</td>
</tr>
</tbody>
</table>

**Coding Guidelines**

“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.” (CMS³)

“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.” (CMS³)

“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.” (CMS⁴)

“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.” (CMS⁵)
“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) (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)

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)

Cross References


References & Resources


IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should 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/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.