

Policy	REIMB-013
Effective Date	09/01/2024
Reviewed/Revised Date	07/17/2024
Next Review Date	07/17/2026
Origination Date	06/01/2024
Originated Department	Medical Management

Modifier -54,-55,-56

Audience
Medical Management, Claims

Purpose
<p>Medical policies provide general support for applying Mountain Health Co-Op member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this medical policy. If there is a conflict between a member-specific policy document and the Mountain Health Co-Op medical policy, the document supersedes this policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health Co-Op medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health Co-Op reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

Definition
<p>Physicians in a group practice should bill for the entire global package if they reassign benefits to the group and all services are performed by two or more physicians within the group. The physician who performs the surgery is shown as the performing physician.</p> <p>When two or more physicians perform the entire surgical package, not in a group practice, the charges are submitted separately. Modifiers identifying the portion of the package performed are appended, and reimbursement is distributed based on the following modifiers:</p> <ul style="list-style-type: none"> • Modifier 54 – Surgical Care Only • Modifier 55 – Postoperative Management Only • Modifier 56 – Preoperative Management Only

Reimbursement is reduced because only one portion of the global surgical package is performed. The total of all the service components for preoperative, postoperative, and surgical care is 100% of the global fee. The global surgical package pertains to major surgical procedures (those defined with a postoperative period of between 10 days and 90 days) and consists of preoperative management, surgical care, and postoperative management.

Policy/Procedure

Commercial Plans/CHIP

Mountain Health Co-Op reimburses for modifiers -54, -55, and -56 when the circumstances of their billing meet CMS coverage guidelines.

Modifier 54: Surgical Care Only

This modifier is used by a physician or other qualified healthcare provider who performs a surgical procedure and transfers the postoperative management to another provider.

Modifier 55: Postoperative Management Only

This modifier is used by the healthcare provider who **only** performs postoperative management.

Modifier 56: Preoperative Management Only

This modifier is used by the healthcare provider who **only** performs preoperative care and does not perform intraoperative (surgical) OR postoperative care.

Modifier reimbursement payment adjustments

Split Surgical Package Modifiers and Reimbursement Percentage		
Modifier 54	Surgical Care Only	70% of the fee schedule (30% reduction)
Modifier 55	Postoperative Care Only	20% of the fee schedule (80% reduction)
Modifier 56	Preoperative Care Only	10% of the fee schedule (90% reduction)

Invalid Procedure Code Split Care Modifier Combinations:

- A. Modifiers 54, 55, or 56 are not considered valid for provider types to which the global surgery concept and postoperative care global period do not apply:
 - i. Assistant Surgeons
 - ii. Ambulatory Surgery Centers
 - iii. Outpatient Hospitals
 - iv. Inpatient Hospitals
- B. Modifiers 54, 55, or 56 are invalid for obstetric care procedure codes. Specific codes already exist to identify when multiple providers perform antepartum, delivery, and postpartum care.
- C. Modifiers 54, 55, or 56 do not apply to procedure codes with a 0-day postoperative period.

- D. Modifiers 54, 55, or 56 are not considered valid for evaluation and management (E/M), anesthesia, radiology, laboratory, medicine, ambulance procedure codes, or any non-surgical HCPCS code.
- E. If the surgeon provided the entire global surgical package personally, the services would be reported as a single claim with the surgical procedure code and the procedure date. 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 claims for both providers will 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.
 - i. Procedure code—The surgeon and physician providing post-operative management will report the same surgical code with their respective modifiers appended.
 - ii. Date of service - Both claims are reported with the date of the surgical procedure as the date of service.
 - iii. Reporting each postoperative care visit with evaluation and management visit codes and modifier 55 appended is inappropriate. Modifier 55 is only appropriate for a procedure code with global follow-up days of 10 or 90 days.
- F. 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.

Applicable Coding

Modifiers

Modifier 54 Surgical Care Only: When 1 (one) physician or other qualified healthcare 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 healthcare 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 healthcare 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.

References

1. Current Procedural Terminology (CPT®) Professional Edition (Chicago, IL: American Medical Association©: 2024).
2. The Centers for Medicare and Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter Physicians/Non-Physician Practitioners, Section 40 Surgeons and Global Surgery

Vendors

- Health Plan Services (HPS)

Review/Revision/Approval History

Date	Description
06/01/2024	New Policy

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