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:	1/8/2025	Last Reviewed:	1/8/2025
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		1/8/2025	

Reimbursement Guidelines

A. General

When the preoperative, intraoperative, and/or postoperative components of a global surgical procedure are furnished by different providers this is known as split surgical care. When surgical care is split, most commonly another provider performs the after-discharge post-operative care (e.g., because of location and distance to the surgeon's office for postoperative visits). Each provider is expected to report only the portion of the service they personally performed. Split care modifiers are used to identify which portion of the global surgery package each provider performed.

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, documented transfer of care is defined as, "in the form of a letter or an annotation in the discharge summary, hospital record, or Ambulatory Surgical Center (ASC) record." [4]
   b. An informal transfer of care is not documented as indicated above but is expected[2] and understood between 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 appropriate transfer of care modifier based on the portion of care they have provided (i.e., modifier 54, 55, or 56).

ii. The surgery date is listed as the date of service[1], in accordance with correct coding guidelines for split surgical care.
iii. Indicate elsewhere on the claim the date care was relinquished or assumed.[2]

b. The receiving physician may not bill for any part of the global follow-up services until after they have provided at least one postoperative visit/service.[1, 2]

3. Beginning in calendar year 2025, when an informal or non-documented transfer of care occurs:
   a. The surgeon is required to bill the surgical code with modifier 54 appended for all 90-day global surgical packages when they do not intend to provide the post-operative care after discharge.
   b. For a practitioner in a different group (TIN) than the surgeon performing an occasional post-discharge postoperative care visit:
      i. Bill the appropriate new or established patient office/outpatient evaluation and management code on the date of service the visit is performed.
      ii. Bill new add-on HCPCS code G0559 on the first visit following the surgical procedure. G0559 may only be billed once per 90-days[3] and represents the one-time additional resource cost spent in providing follow up post-operative care 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 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. [2, 5]
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.

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.

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." [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." [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." [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." [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." [1] (bold 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." [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." [1]

Cross References

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.

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, 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.

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
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.

Date	Summary of Update
7/13/2022	Updated Acronyms & 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])