Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Modifiers: This MAC Clarifies Use of Modifiers 54, 55 When Co-Managing Patients

Surgery from one practice and postoperative care from another? It is possible to collect for both.

Picture this: A physician diagnoses a hip fracture and performs surgery in Florida, where the patient had been vacationing, then releases the patient, who goes back to her home in Georgia, where a different physician performs all of the postoperative care. Can both physicians collect for their portions of the global surgery fee? The answer is yesif you know your modifiers.

This situation is rather common, and not just for vacationing patients. In some cases, physicians will be unable to perform follow-up care after a patient's surgery, and that leaves another physician to take over care until the global ends. Because this situation is confusing to so many practices, one MAC recently sent out an article clarifying how to bill under these circumstances.

Know the Rules

"When physicians agree on the transfer of care during the global period, use the following modifiers," says an article that NGS Medicare published on Oct. 18. "Modifier 54 for surgical care only, or modifier 55 for postoperative management only."

Therefore, in our example above, the surgeon in Florida would append modifier 54 to his surgical claim (such as 27236-54) and the doctor in Georgia would append modifier 55 to the same code (for instance, 27236-55).

See the patient first: Although you don't need to specify the transfer of care on the claim, you do need to document the date that care was relinquished or assumed, the article says. "When a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he has provided at least one service," NGS says in the article. "Once the physician has seen the patient, that physician may bill for the period beginning with the date on which he assumes care of the patient."

Avoid Modifier 56

When you attach modifier 54 to a claim, you're telling your carrier that the physician performed the surgical procedure but not the postoperative services.

Note: Medicare includes the service's preoperative reimbursement in the payment to the physician who performed the surgery. Medicare does not recognize modifier 56 (Preoperative management only). If your physician performs only a procedure's postoperative care, you should append modifier 55 to the procedure code.

How payment works: Most surgical CPT® codes are broken down into a 10/70/20 split. This means, of the total allowable for the CPT® code, 10 percent is allocated for preoperative work, 70 percent for the surgical portion and 20 percent for postoperative work. (Note that these percentages are only averages, and CPT® code interservice values may vary.)

Example 1: A rural urologist sends his patient to an academic institution in the city and to an oncological urologist for an open radical retropubic prostatectomy with nodes. Following surgery, the oncological urologist returns the patient to his local urologist for postop care. The academic urologist should report the surgical code (55845, Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes) and attach modifier 54. The rural urologist will report the same procedure code and append modifier 55

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with the date of his care the same as the date of the surgery.

Example 2: An ophthalmologist performs cataract surgery for a patient who lives out of town and then sends the patient back to his local optometrist for post-op care. You should report the surgical code - such as 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis [one-stage procedure], manual or mechanical technique [e.g., irrigation and aspiration or phacoemulsification]) or, less frequently, 66982 (... complex, requiring devices or techniques not generally used in routine cataract surgery [eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis] or performed on patients in the amblyogenic developmental stage)--and attach modifier 54. The optometrist will report the same procedure code and append modifier 55.

Remember: You must ensure both physicians' offices coordinate postoperative care and enter the number of postop care days each sees the patient and submit them on separate claim forms. For example, the oncological urologist often will want to see the patient for at least the initial postoperative days before releasing further care to the rural-based urologist.

Caution: If you're reporting the postoperative care using modifier 55, make sure the surgeon who performed the procedure reported the service with modifier 54. Otherwise the carrier will deny your claim because it has already reimbursed the surgeon for providing the full care associated with the code.

Know These Exceptions

Not all of your visits for a postsurgical patient will qualify you to report modifier 55. Instead, there must be a true transfer of care before you can bill it. Note these exceptions that NGS outlines in its recent article:

- If you see a patient post-discharge but the original surgeon didn't transfer care to you, then report the appropriate E/M code rather than billing the surgical code with modifier 55. You don't need to append any modifiers to your E/M code.
- If the transfer of care occurs immediately after surgery, the physician other than the surgeon who provides in-hospital postoperative care should use subsequent hospital care codes for the inpatient hospital care and the surgical code with modifier 55 for the post-discharge care. The surgeon bills the surgery code with modifier 54.
- Physicians who provide follow-up services for minor procedures performed in emergency departments should bill the appropriate E/M code. The physician who performs the emergency room service bills for the surgical procedure without a modifier.
- If the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician reports an E/M code and no modifiers are necessary on the claim. For instance, if your doctor manages the patient's diabetes, you'd keep billing the appropriate E/M codes for your services despite the fact that the patient recently had surgery.

Two Carriers Might Be Involved

If, as in our example at the beginning of this article, the surgical portion of the global service occurs in one payment locality and the postsurgery portion takes place in another MAC's jurisdiction, you'll bill only your own MAC and not the other physician's carrier. "For example," NGS states in its article, "if the surgery is performed in one state and the postoperative care is provided in another state, the surgery is billed with modifier 54 to the contractor servicing the payment locality where the surgery was performed, and the postoperative care is billed with modifier 55 to the contractor servicing the payment locality where the postoperative care was performed. This is true whether the services were performed by the same physician/group or different physicians/groups."

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