Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Expert Tips Ensure You Apply Modifiers 54 and 55 Correctly

You-re in for a world of denials if you miss this coordination tip

If your physician is co-managing a patient's case with another physician, you may be tempted to automatically apply modifier 54 or 55, depending on your physician's work. If you-re not careful, however, you could be raising a red flag with Medicare and your other payers.

Key points: Make sure you append a co-management modifier only when both physicians share the patient's care, and ensure that you-re performing the co-management service for the patient's benefit, not for the practice's financial benefit. Your physician needs to document the reason for this approach to providing shared care in the medical record prior to the surgery, as well as the patient's request for, understanding of and agreement to this care plan.

Organize or Miss Out on 55 Pay

You should append modifier 54 (Surgical care only) to the procedure code when the physician provided only the surgical portion of a CPT code, says **Regan Bode, CPC, CPC-EM, ACS-EM, OCS**, product manager for **Custom Coding Books** in Seattle. In other words, when you attach modifier 54, 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), says **Maggie M. Mac, CMM, CPC, CMSCS, CCP, ICCE**, consulting manager for Pershing, Yoakley & Associates in Clearwater, Fla.

If your physician performs only a procedure's postoperative care, you should append modifier 55 (Post-operative management only) to the procedure code.

How it works: -Most surgical CPT codes are broken down into a 10/70/20 split,- Bode says -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 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 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, Mac says. 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. As often happens, this is difficult to coordinate, and the physician who performs postop care may choose to report an appropriate E/M code whenever he sees the patient rather than using modifier 55 for the follow-up care.