Codify
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Modifier Coding Alert

Surgery Modifiers: Focus on Who Did What When Choosing Modifier 54, 55, or 56

Ensure a transfer of care before attaching the modifier.

When one of your physicians is providing a portion of the care within a global surgical package, using the right modifier is critical to avoiding a denial. Submit the claim without a modifier or with the wrong modifier and you may not get any reimbursement at all. But remembering which modifier applies in which situation can be a challenge.

Read more about modifiers 54, 55, and 56 so your claims accurately depict the encounters to your payers.

Expect Separate Payment for Shared Surgical Care

When two physicians provide services within the global surgical period, payers will split the total reimbursement for any care related to the surgery among the two physicians when they agree on the transfer of care.

According to CMS, "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 provides all services (except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative care, result in payment that is higher than the global allowed amount)."

How it works: When the surgeon performs only the surgery and a physician other than the surgeon furnishes pre-operative and/or post-operative care, payment for the postoperative or post-discharge care should be split between the physicians when they agree on the transfer of care, continues CMS. You will use the following modifiers to explain the division of services:

- 54 – Surgical care only
- 55 – Postoperative management only
- 56 – Preoperative management only.

When you attach modifier 54 to a claim, you're telling the payer that your physician performed only the surgery, not the pre- or post-operative care. If your physician only performs the postoperative services, you will attach modifier 55 to the procedure code. If your physician performs only pre-operative services, you'll use modifier 56.

Review 2 Examples

The most common example for using 54 and 55 is a vacationing patient who requires surgery and returns home for the postoperative care. Other examples might relate to the need for a specialist or a surgeon who is unable to complete post-operative care.

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 attach modifier 55.

Example 2: A surgeon performs a tonsillectomy (42826, Tonsillectomy, primary or secondary; age 12 or over) on a 13-

year-old patient. Immediately following the procedure, the surgeon is called out of town for a personal emergency. One of your physicians (not in the same practice as the surgeon) accepts the transfer of care for the post-operative care of the patient.

Code it: The surgeon will report 42826 with modifier 54 attached. Your physician will report 42826 with modifier 55. The date of the transfer should be available in a written transfer of care document.

Connect with the Other Practice

In order for you to use the right modifier when another practice provides a portion of the surgical care for one of your patients, you have to connect with that other practice. You need to make sure that both physicians' offices coordinate the postoperative care and enter the number of postop care days that they each see the patient and submit them on separate claim forms. The oncological urologist in the scenario above may want to see the patient for at least the initial postoperative days before turning over the care to the rural-based urologist, for example.

"The largest hurdle regarding these modifiers is knowing the other office," stresses **Suzan Berman (Hauptman), MPM, CPC, CEMC, CEDC**, manager of physician compliance auditing at Allegheny Health Network in Pittsburgh, Penn. "If your physician did the surgery but won't be following the patient as she'll be going to recover at her son's house in another city, then in order to bill correctly, you should communicate with that office. You would then bill for the pre-op and surgery, the other office would bill for the post op care; everyone would use the same surgery CPT® code instead of E/M service codes for the post-op care."

Another, more complicated, hurdle may be when the patient expresses dissatisfaction with a physician and requests a different one. For example, "If the patient had the surgery by Dr. A and did not like her, the patient would rather be followed by a different physician in a different group for his post-op care, the communication between the two offices might not be as straightforward," continues Hauptman. "Dr. A might not know that the patient isn't following with her. Dr. B might not know where the surgery was originally done or how to get in contact with Dr. A's office."

Red flag: If you're reporting the postop care with modifier 55, you need to make sure the physician who performed the surgery reports the surgery with modifier 54. If you don't, the payer will deny your claim because they may have already reimbursed the surgeon for the full care associated with the code.

"This is where communication between offices is critical. If one of the offices mistakenly forgets to append a modifier, a corrected claim can be sent in to the health plan in order to ensure proper payments to both offices," says **Betty A. Hovey, CPC, CPC-H, CPB, CPMA, CPC-I, CPCD**, director, ICD-10 Development and Training at the AAPC in Salt Lake City.

Find Out What Your Payers Accept

When payers receive claims with modifiers 54, 55, or 56, they split the surgical package payment between different providers instead of paying the full package amount to one provider. Each payer has its own guidelines for the amount it will reimburse each provider. Payers typically pay a percentage of the full payment to each provider, with the highest percentage paid to the provider who rendered intraoperative services.

Warning: Some payers do not recognize these modifiers and will only pay the package payment to one provider. For example, if you are reporting the service to Medicare and use modifier 54, your physician will receive the preoperative reimbursement because Medicare includes it in the payment. This explains why Medicare doesn't recognize modifier 56.

Caveat: If the surgeon and the postoperative care physician perform services in the same Part B contractor jurisdiction, they should both submit their claim to the same MAC. If they don't, the surgeon should send his claim with modifier 54 to the MAC who covers the area where the surgery is performed. The doctor who performs postoperative care should bill the claim with modifier 55 to the MAC that covers the area where the postsurgical care occurs.