Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-005		
Subject:	Modifiers 54, 55 and 56		
Effective Date:	August 1, 2016	**End Date:**	
Issue Date:	September 1, 2022	**Revised Date:**	August 2022
Date Reviewed:	August 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy addresses the indications and limitations of co-management of surgical procedures that carry a 10- or 90-day global period. It also provides guidelines for proper billing and documentation and use of modifier 54, 55 and 56, in claim submission.

REIMBURSEMENT GUIDELINES:

Management of a surgical procedure is the primary responsibility of the operating surgeon. Physicians who perform surgery and furnish all the usual pre- and post-operative work should bill for global surgical care using the proper CPT surgical code(s).

Physicians should not bill separately for visits or other services that are included in the global package. Occasionally, a physician must transfer the care of the patient during the global period.

In these instances, modifiers 54, 55 and 56 are used to distinguish who is providing care for the patient.

Modifier 54: Surgical Care Only

This modifier is used by a physician or other qualified health care professional who performs a surgical procedure and transferred the postoperative management to another provider. This modifier is appended to the surgical procedure code.

Modifier 55: Postoperative Management Only

This modifier is used by the physician who provides postoperative care only. This modifier is appended to the surgical procedure code.

The physician receiving the patient must be licensed to manage all aspects of the postoperative care, including the ability to diagnose potential complications that would require another operation.

In all instances the transfer of global surgery must be clinically necessary and appropriate. The transfer of surgical care is allowed only to protect the legitimate interest of the member as outlined below under Indications and Limitations.

Modifier 56: Preoperative Management Only

This modifier is used by a physician or other qualified health care professional who performs preoperative care but does not provide the intraoperative (surgical) or postoperative services. This modifier is appended to the surgical procedure code.

Modifier Reimbursement

Commercial

For claims processed on or after November 1, 2021 modifiers 54, 55 and 56 are reimbursed as follows:

Modifier 54 - The Plan will reimburse claim lines at 70% of the approved allowance.

Modifier 55 - The Plan will reimburse claim lines at 20% of the approved allowance.

Modifier 56 - The Plan will reimburse claim lines at 10% of the approved allowance.

For claims processed before November 1, 2021, see previous versions of this policy by clicking the HISTORY VERSION link at the top of this policy.

Medicare Advantage (PA, WV, DE only)

Modifier 54 - The Plan will reimburse claim lines at the code specific pre-op and intra-op percentages (of the approved allowance) as defined on the Medicare Physician Fee Schedule (MPFS).

Modifier 55 - The Plan will reimburse claim lines at the code specific post-op percentages (of the approved allowance) as defined on the Medicare Physician Fee Schedule (MPFS) multiplied by the percentage of the post-op period for which the physician provided care.

Modifier 56 - The Plan does not apply a reduction.

Medicare Advantage (NY only)

Modifier 54 - The Plan will reimburse claim lines at 70% of the approved allowance.

Modifier 55 - The Plan will reimburse claim lines at 20% of the approved allowance.

Modifier 56 - The Plan will reimburse claim lines at 10% of the approved allowance.

Invalid Procedure Code Split Care Modifier Combinations

1. 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:

    A. Assistant Surgeons
    B. Ambulatory Surgery Centers
    C. Outpatient Hospitals
    D. Inpatient Hospitals

2. Modifiers 54, 55, or 56 are not considered valid for obstetric care procedure codes. Specific codes already exist to identify when more than one provider performs antepartum, delivery, and postpartum care.

3. Modifiers 54, 55, or 56 do not apply to procedure codes with a 0-day postoperative period.

4. Modifiers 54, 55, or 56 are not considered valid for evaluation and management (E/M), anesthesia, radiology, laboratory, medicine, or ambulance procedure codes, or any non-surgical HCPCS code.

Indications and Limitations of Coverage

Co-management is indicated under any of the following circumstances:

- The operating surgeon is unavailable after surgery and the patient's post-operative care has to be managed by another physician.
- The member is unable to travel the distance to the surgeon's office for post-operative care visits.
- The patient voluntarily wishes to be followed post-operatively by another physician.
- The surgery is performed by an itinerant surgeon in a remote area of the country.
- The care is provided in a health professional shortage area (HPSA) and the member is unable to travel to the surgeon's office.
- The surgeon practices in a site remote from where the patient recuperates, e.g. the surgery is performed in a remote area and the surgeon does not return to the area frequently enough to provide the preoperative or postoperative care.
- A second illness has developed which prevents travel to the operating surgeon.
- A surgery is performed at a site that is far away or while the patient is traveling, vacationing or temporarily living in a distant location.

Limitations

The transfer of postoperative care is not covered if:

- The operating surgeon is available and he/she is able to manage other patients postoperatively, unless the patient voluntarily wishes to be followed postoperatively by another provider.
- The surgeon does follow the patient postoperatively but splits the fee with another provider.

- Two or more physicians co-manage patients indiscriminately as a matter of policy and not on a case-by-case basis.
- A physician demands to manage the postoperative care and indicates he/she will withhold making referrals to surgeons who would not agree to split global surgery payments.
- A surgeon opts to transfer postoperative management but follows the patient postoperatively as he/she would have done without transferring postoperative care.
- The transfer is not made in writing.
- The transfer of care is used as an incentive for obtaining referrals from providers to receive postoperative care reimbursement.
- The patient has not consented to transfer of care even after being apprised of the medical and/or logistic advisability, or the risks and benefits of transfer of care.

A claim for co-management will be denied if:

- Any of the circumstances listed in the "Limitations" subsection of this policy apply.
- The medical record does not support the "Documentation Requirements" section of this policy.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.
3. The submitted medical record should support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
4. The medical record documentation must support the medical necessity of the services as directed in this policy.
5. The surgeon should write his/her usual operative note. The physician providing postoperative care should document appropriate follow-up care notes.
6. Transfer of Care must be in writing and dated. The record must indicate the exact date on which post-operative care is assumed by the co-managing physician.
7. Additionally, the medical record must indicate that the patient was appropriately informed of the medical and/or logistic advisability of transfer of care along with any risks or benefits of this arrangement, and that the patient gave consent to this arrangement prior to its inception.

The documentation that the patient was properly informed as described above, must be made available upon request.

RELATED HIGHMARK POLICIES:

Refer to the following Medicare Advantage Medical Policies for additional information:

- S-199: Co-management of Surgical Procedures

POLICY UPDATE HISTORY INFORMATION:

1 / 2016	Implementation
11 / 2021	Added NY region applicable to the policy. Add modifier 56 direction and reduction applicable to all regions. Changed modifier 54 reduction.
9 / 2022	Added Medicare Advantage direction applicable to all regions.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-005		
Subject:	Modifiers 54, 55 and 56		
Effective Date:	August 1, 2016	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☐	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy addresses the indications and limitations of co-management of surgical procedures that carry a 10- or 90-day global period. It also provides guidelines for proper billing and documentation and use of modifier 54, 55 and 56, in claim submission.

REIMBURSEMENT GUIDELINES:

Management of a surgical procedure is the primary responsibility of the operating surgeon. Physicians who perform surgery and furnish all the usual pre- and post-operative work should bill for global surgical care using the proper CPT surgical code(s).

Physicians should not bill separately for visits or other services that are included in the global package. Occasionally, a physician must transfer the care of the patient during the global period.

In these instances, modifiers 54, 55 and 56 are used to distinguish who is providing care for the patient.

Modifier 54: Surgical Care Only

This modifier is used by a physician or other qualified health care professional who performs a surgical procedure and transferred the postoperative management to another provider. This modifier is appended to the surgical procedure code.

Modifier 55: Postoperative Management Only

This modifier is used by the physician who provides postoperative care only. This modifier is appended to the surgical procedure code.

The physician receiving the patient must be licensed to manage all aspects of the postoperative care, including the ability to diagnose potential complications that would require another operation.

In all instances the transfer of global surgery must be clinically necessary and appropriate. The transfer of surgical care is allowed only to protect the legitimate interest of the member as outlined below under Indications and Limitations.

Modifier 56: Preoperative Management Only

This modifier is used by a physician or other qualified health care professional who performs preoperative care but does not provide the intraoperative (surgical) or postoperative services. This modifier is appended to the surgical procedure code.

Modifier Reimbursement Adjustments

For claims processed on or after November 1, 2021 modifiers 54, 55 and 56 are reimbursed as follows:

Modifier 54 - The Plan will reimburse claim lines at 70% of the approved allowance.

Modifier 55 - The Plan will reimburse claim lines at 20% of the approved allowance.

Modifier 56 - The Plan will reimburse claim lines at 10% of the approved allowance.

For claims processed before November 1, 2021 see previous versions of this policy by clicking the HISTORY VERSION link at the top of this policy.

Invalid Procedure Code Split Care Modifier Combinations

1. 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:

   A. Assistant Surgeons
   B. Ambulatory Surgery Centers
   C. Outpatient Hospitals
   D. Inpatient Hospitals

2. Modifiers 54, 55, or 56 are not considered valid for obstetric care procedure codes. Specific codes already exist to identify when more than one provider performs antepartum, delivery, and postpartum care.

3. Modifiers 54, 55, or 56 do not apply to procedure codes with a 0-day postoperative period.

4. Modifiers 54, 55, or 56 are not considered valid for evaluation and management (E/M), anesthesia, radiology, laboratory, medicine, or ambulance procedure codes, or any non-surgical HCPCS code.

Indications and Limitations of Coverage

Co-management is indicated under any of the following circumstances:

- The operating surgeon is unavailable after surgery and the patient's post-operative care has to be managed by another physician.
- The member is unable to travel the distance to the surgeon's office for post-operative care visits.
- The patient voluntarily wishes to be followed post-operatively by another physician.
- The surgery is performed by an itinerant surgeon in a remote area of the country.
- The care is provided in a health professional shortage area (HPSA) and the member is unable to travel to the surgeon's office.
- The surgeon practices in a site remote from where the patient recuperates, e.g. the surgery is performed in a remote area and the surgeon does not return to the area frequently enough to provide the preoperative or postoperative care.
- A second illness has developed which prevents travel to the operating surgeon.
- A surgery is performed at a site that is far away or while the patient is traveling, vacationing or temporarily living in a distant location.

Limitations

The transfer of postoperative care is not covered if:

- The operating surgeon is available and he/she is able to manage other patients postoperatively, unless the patient voluntarily wishes to be followed postoperatively by another provider.
- The surgeon does follow the patient postoperatively but splits the fee with another provider.
- Two or more physicians co-manage patients indiscriminately as a matter of policy and not on a case-by-case basis.
- A physician demands to manage the postoperative care and indicates he/she will withhold making referrals to surgeons who would not agree to split global surgery payments.
- A surgeon opts to transfer postoperative management but follows the patient postoperatively as he/she would have done without transferring postoperative care.
- The transfer is not made in writing.
- The transfer of care is used as an incentive for obtaining referrals from providers to receive postoperative care reimbursement.
- The patient has not consented to transfer of care even after being apprised of the medical and/or logistic advisability, or the risks and benefits of transfer of care.

A claim for co-management will be denied if:

- Any of the circumstances listed in the "Limitations" subsection of this policy apply.
- The medical record does not support the "Documentation Requirements" section of this policy.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.
3. The submitted medical record should support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
4. The medical record documentation must support the medical necessity of the services as directed in this policy.
5. The surgeon should write his/her usual operative note. The physician providing postoperative care should document appropriate follow-up care notes.
6. Transfer of Care must be in writing and dated. The record must indicate the exact date on which post-operative care is assumed by the co-managing physician.
7. Additionally, the medical record must indicate that the patient was appropriately informed of the medical and/or logistic advisability of transfer of care along with any risks or benefits of this arrangement, and that the patient gave consent to this arrangement prior to its inception.

The documentation that the patient was properly informed as described above, must be made available upon request.

RELATED HIGHMARK POLICIES:

Refer to the following Medicare Advantage Medical Policies for additional information:

- S-199: Co-management of Surgical Procedures

POLICY UPDATE HISTORY INFORMATION:

1 / 2016	Implementation
11 / 2021	Added NY region applicable to the policy. Add modifier 56 direction and reduction applicable to all regions. Changed modifier 54 reduction.

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-005		
Subject:	Modifiers 54 and 55		
Effective Date:	August 1, 2016	**End Date:**	
Issue Date:	January 1, 2018		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐		
Applicable Claim Type	**UB**	☐	**1500**	☒		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreements supersede Reimbursement Policy direction and regional applicability.

PURPOSE:

This policy addresses the indications and limitations of co-management of surgical procedures that carry a 10 or 90 day global period. It also provides guidelines for proper billing and documentation.

Management of a surgical procedure is the primary responsibility of the operating surgeon. Physicians who perform surgery, and furnish all the usual pre and post-operative work should bill for global surgical care using the proper CPT surgical code(s). Physicians should not bill separately for visits or other services that are included in the global package.

Occasionally, a physician must transfer the care of the patient during the global period. In these instances, modifier 54 and 55 are used to distinguish who is providing care for the patient.

Modifier-54: Surgical Care Only

This modifier is used by the surgeon and when another physician provides preoperative and/or postoperative care. This modifier is appended to the surgical procedure code.

Modifier-55: Postoperative Management Only

This modifier is used by the physician who provides postoperative care when another physician has done the surgical procedure. This modifier is appended to the surgical procedure code.

The physician receiving the patient must be licensed to manage all aspects of the postoperative care, including the ability to diagnose potential complications that would require another operation.

In all instances the transfer of global surgery must be clinically necessary and appropriate. The transfer of surgical care is allowed only to protect the legitimate interest of the member as outlined below under Indications and Limitations.

Indications and Limitations of Coverage

Co-management is indicated under any of the following circumstances:

- The operating surgeon is unavailable after surgery and the patient's post-operative care has to be managed by another physician.
- The member is unable to travel the distance to the surgeon's office for post-operative care visits.
- The patient voluntarily wishes to be followed post-operatively by another physician.
- The surgery is performed by an itinerant surgeon in a remote area of the country.
- The care is provided in a health professional shortage area (HPSA) and the member is unable to travel to the surgeon's office.
- The surgeon practices in a site remote from where the patient recuperates, e.g. the surgery is performed in a remote area and the surgeon does not return to the area frequently enough to provide the preoperative or postoperative care.
- A second illness has developed which prevents travel to the operating surgeon.
- A surgery is performed at a site that is far away or while the patient is traveling, vacationing or temporarily living in a distant location.

Limitations

The transfer of postoperative care is not covered if:

- The operating surgeon is available and he/she is able to manage other patients postoperatively, unless the patient voluntarily wishes to be followed postoperatively by another provider.
- The surgeon does follow the patient postoperatively but splits the fee with another provider.
- Two or more physicians co-manage patients indiscriminately as a matter of policy and not on a case by case basis.
- A physician demands to manage the postoperative care and indicates he/she will withhold making referrals to surgeons who would not agree to split global surgery payments.
- A surgeon opts to transfer postoperative management but follows the patient postoperatively as he/she would have done without transferring postoperative care.
- The transfer is not made in writing.
- The transfer of care is used as an incentive for obtaining referrals from providers to receive postoperative care reimbursement.
- The patient has not consented to transfer of care even after being apprised of the medical and/or logistic advisability, or the risks and benefits of transfer of care.

A claim for co-management will be denied if:

- Any of the circumstances listed in the "Limitations" subsection of this policy apply.
- The medical record does not support the "Documentation Requirements" section of this policy.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.
3. The submitted medical record should support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
4. The medical record documentation must support the medical necessity of the services as directed in this policy.
5. The surgeon should write his/her usual operative note. The physician providing postoperative care should document appropriate follow-up care notes.
6. Transfer of Care must be in writing and dated. The record must indicate the exact date on which post-operative care is assumed by the co-managing physician.
7. Additionally, the medical record must indicate that the patient was appropriately informed of the medical and/or logistic advisability of transfer of care along with any risks or benefits of this arrangement, and that the patient gave consent to this arrangement prior to its inception.
8. The documentation that the patient was properly informed as described above, must be made available upon request.

REIMBURSEMENT GUIDELINES:

The Plan will reimburse approved service lines reporting modifier 54 at 60% of the allowance.

The Plan will reimburse approved service lines reporting modifier 55 at 20% of the allowance.

RELATED POLICIES:

Refer to the following Medical Policies for additional information:

- Medicare Advantage Policy S-199: Co-management of Surgical Procedures