

TRANSFER OF CARE & GLOBAL PERIOD

Using Modifiers 54, 55, & 56

Global Surgery Coding and Billing Guidelines

- Physicians who furnish the surgery and furnish all the usual pre-and post-operative care should bill for the global package by entering the appropriate surgical procedure CPT code. Separate billing is not allowed for visits or other services that are included in the global package.
- When different physicians in a group practice (same specialty) participate in the care of the patient, the group practice bills for the entire global package. The physician who performs the surgery is reported as the performing physician.

Billing the Global Package

Those procedures with a 10-day or 90-day global period are assigned separate values for pre-procedure, intra-procedure, and post-procedure reimbursement. You can find these valuations in the Medicare Physician Fee Schedule [Relative Value File](#). The columns labeled “PRE OP,” “POST OP,” and “INTRA OP” list the percentage value that Medicare will reimburse for only that portion of the procedure (the total of the three columns is 1.00).

HCPCS	MOD	DESCRIPTION	GLOB DAYS	PRE OP	INTRA OP	POST OP
27612		Exploration of ankle joint	090	0.10	0.69	0.21
27613		Biopsy lower leg soft tissue	010	0.10	0.80	0.10

When a healthcare provider performs a surgery, including all usual pre- and post-operative care, they may report that procedure using the appropriate CPT code for the surgical procedure, only. Do not separately bill for visits or other services included in the global package.

Transfer of Care Cinches Modifier 54

If the provider who performs the surgical procedure only (e.g., the “intraoperative” portion of the service), and does not furnish the follow-up care, the post-operative care is paid separately if the provider who performed the surgery and the provider who performs the post-op care agree on a transfer of care.

The provider who performed surgical care should append [modifier 54](#) to the appropriate CPT code(s) to describe the surgery performed. The modifier signals that the surgeon intends to relinquish “all or part of the post-operative care” to another provider, per CMS.

The physician who provides post-operative care should report the same code(s) as the surgeon, but with modifier 55 appended. The physician should not bill until they have provided at least one service. CMS advises, “Report the date of surgery as the date of service and indicate the date that care was relinquished or assumed. Physicians must keep copies of the written transfer agreement in the beneficiary’s medical record.”

For example:

An emergency department physician may reduce a fracture and place a cast. Per a transfer of care agreement, the patient later follows-up with their family physician. The ED physician would report the appropriate fracture care code(s) with modifier 54 appended. The family physician would report the same code(s), but with modifier 55 appended.

Per Medicare rules, “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.”

[The Takeaway:](#) When appending modifier 54 or modifier 55, you must coordinate your coding with that of the physician who provides the other portion of care. Failure to cooperate in this way will likely result in one physician (usually the physician who provides post-operative care) missing out on reimbursement.

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When **NOT** to use 54 and 55

CMS allows exceptions to the use of modifiers 54 and 55 for follow-up services during a post-operative period in the following circumstances:

- Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate E/M code. No modifiers are necessary on the claim
- Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of E/M code, without a modifier
- If the services of a physician, other than the surgeon, are required during a post-operative period for an underlying condition or medical complication, the other physician reports the appropriate E/M code. No modifiers are necessary on the claim. An example is a cardiologist who manages underlying cardiovascular conditions of a patient. For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Sections 40.2 and 40.4

Medicare Won't Accept Modifier 56

Modifier 56 *Pre-operative management only* describes a provider's pre-operative services, only. Medicare does not recognize modifier 56, and instead includes pre-operative care in the payment for the intraoperative portion of the service. Guidelines may differ for other payers.

Pre-operative Care (modifier -56)

During the pre-operative visit, the surgeon discusses the surgery to be performed, evaluates the patient's condition and ability to tolerate the planned surgery, prepares the admission documents, and has the patient sign the appropriate consent forms. **These services are not customarily delegated to another physician.**

For example:

If abdominal surgery is planned for a patient with underlying heart disease, the surgeon may wish to have the patient's cardiologist examine the patient and give the patient a pre-operative clearance. In this instance, the surgeon will still do the routine pre-operative care and the cardiologist will bill for an established patient office visit for the pre-operative clearance. **(The cardiologist would NOT bill the surgical code with modifier 56.)**

Post-operative Care (modifier -55)

During the post-operative period for a major surgery (90 days), the surgeon performs routine post-operative care.

However, there may be times when a surgeon chooses to turn over the post-operative care to the patient's internist.

For example:

A patient from a Neighbor Island may have surgery on Oahu and receive post-operative care from an internist at home. Because the post-operative care is included in payment for the surgical package, the internist should not bill for office visits. The surgeon and the internist should reach an agreement about sharing payment for the surgery. The internist will then bill for post-operative care using the surgical procedure code and modifier -55.

Surgical Care Only (modifier -54)

If a surgeon has performed the surgery only, the surgeon will bill using the surgical procedure code and modifier -54. If the surgeon has billed the pre-operative care and the surgery but has turned over the post-operative care to another physician, the surgeon will bill using the surgical procedure and modifiers -54 & -56.

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Correct use of modifier 55:

- Surgeon performs part of post-operative care
 - Submit claim with two lines using same date of service and procedure code; append modifier to line 2
 - Include date span in item 19 narrative of CMS-1500 claim form or electronic equivalent
 - Submit claim with number of units as 1
- Physician rendering additional post-operative care
 - Submit claim with surgery date and procedure code
 - Include date span of assumed care in Item 19 narrative of CMS-1500 claim form or electronic equivalent
 - Submit claim with number of units as 1

Incorrect use of modifier 55:

- Do not append modifier 55 when surgeon performs surgery only: no post-operative care (see modifier 54)
- Do not append modifier 55 if patient is under surgeon's care for full 10 or 90 days of post-operative care
- Do not append on ASC facility or assistant surgeons claims

The physician must use the same CPT code for global surgery services billed with modifiers “-54” or “-55.” The same date of service and surgical procedure code should be reported on the bill for the surgical care only and post-operative care only. The date of service is the date the surgical procedure was furnished.

Modifier “-54” indicates that the surgeon is relinquishing all or part of the post-operative care to a physician.

The physician, other than the surgeon, who furnishes post-operative management services, bills with modifier “-55.”

For information on the global period and other related modifiers see coding corner [Surgery Modifiers & Global Period](#)

Resources:

1. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf>
2. <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeeschedpfs-relative-value-files/rvu20a>
3. <https://www.aapc.com/blog/44326-modifier-54-mastery/>
4. https://hmsa.com/portal/provider/zav_pel.ph.MOD.600.htm
5. <http://www.medicalbillingcptmodifiers.com/2010/08/usage-of-medicare-modifier-55.html>