
TITLE: Physicians Furnishing Less Than the Full Global Package – Use of Modifiers -54 and -55

POLICY/PURPOSE: There are occasions when more than one physician provides services included in the global surgical package. This policy provides instruction on how to bill properly when two physicians provide less than the full global surgery package.

It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the postoperative, post-discharge care is split between two or more physicians where the physicians agree on the transfer of care.

Where physicians agree on the transfer of care during the global period, Modifiers -54 and -55 are used.

DEFINITIONS:

1. **Modifier -54: Surgical Care Only** – When one physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding Modifier -54 to the surgical code.
2. **Modifier -55: Postoperative Management Only** – When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding Modifier -55 to the surgical procedure code.
3. **Same Physician** – Per Medicare, a physician of the same specialty in the same group as another physician.

PROCEDURE:

1. **Billing Requirements**
 - A. Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier.

- B. Providers need not specify on the claim that care has been transferred. However, the date on which care was relinquished or assumed, as applicable, must be shown on the claim. This should be indicated in the remarks field/free text segment on the claim form/format. Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary's medical record.
- C. Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service. Once the physician has seen the patient, that physician may bill for the period beginning with the date on which he/she assumes care of the patient.
- D. If the transfer of care occurs immediately after surgery, the physician other than the surgeon who provides the in-hospital postoperative care bills using 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.
- E. When postoperative critical care services (for procedures with a global surgical period) are provided by a physician other than surgeon, no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, Modifiers -54 (surgical care only) and -55 (postoperative management only) must be used by the surgeon and intensivist who are submitting claims. Medical record documentation by the surgeon and the physician who assumes a transfer (e.g., intensivist) is required to support claims for services when Modifiers -54 and -55 are used indicating the transfer of care from the surgeon to the intensivist. Critical care services must meet all the conditions for critical care.
- F. 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.

2. Exceptions

- A. 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.
- B. Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier.

- C. 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 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.

REFERENCES: CMS. Medicare Claims Processing Manual Pub. # 100-04. Ch. 12. § 40.2

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