Co-management of Surgical Care
Use of Modifiers 54, 55 & 56

Last revised: August, 21, 2024

Scope and history

This guide applies to all providers, non-physician providers and subcontractors who submit surgical service claims. The purpose of this guide is to provide direction on CareOregon policy for billing for the co-management of surgical care using modifiers 54, 55 and 56.

When a single physician or physician group performs a surgery and handles all the usual pre- and post-operative work, they should bill for global surgical care using the appropriate CPT surgical code(s). In this scenario, physicians should not bill separately for visits or other services included in the global package, and no modifier is necessary.

However, there are occasions when a physician must transfer the care of a patient during the global care period. In these instances, modifiers are necessary to distinguish who is providing care for the patient.

Reasons for splitting care:

- The operating surgeon is unavailable after surgery and the patient's postoperative care has to be managed by another physician.
- The patient is unable to travel the distance to the surgeon's office for postoperative care visits.
- The care is provided in a health professional shortage area (HPSA) and the patient 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.
- The patient voluntarily wishes to be followed postoperatively by another physician.
- The surgery is performed by an itinerant surgeon in a remote area of the country.

Policy/guidelines

When physicians agree to transfer care during a 10-day or 90-day global period, payment for the surgery will be split between the providers. The following modifiers are used to indicate co-management of surgical care and determine pricing:

54 Surgical Care Only
55 Postoperative Management Only
56 Preoperative Management Only

Modifier 54 surgical care only

Modifier 54 is used when the same provider completes the surgery and preoperative management. A separate claim with modifier 56 for preoperative management is not required. The reimbursement for modifier 54 claims will include the expenses associated with preoperative management unless a separate claim is received from a different provider or practice that bills for the surgery code on the same date of service using modifier 56. When a claim is received with modifier 54, payment for the services billed will be calculated to include Pre-op % and Intra-op % from the Medicare Physician Fee Schedule.

Fee schedule amount for the code x (pre-op % + intra-op %)

Example:
CPT 66984 with modifier 54
Medicare physician fee schedule (MPFS) shows the pre-operative portion of the payment is 10% and the intra-operative portion of the payment is 70% of the fee schedule amount for this code, for a total of 80%.

- The total OHA Non-facility rate of $405.65
  $405.65 x (0.10 + 0.70) = $405.62 x 0.80 =
  $324.52 is the allowed amount for the services

		2024 National Physician Fee Schedule Re					
		CPT codes and descriptions only are copyright 2023 Ameri					
		Dental codes (D codes) are copyright 2024/25 American De					
		RELEASED 12/14/2023					
				NOT USED			
				FOR			
			STATUS	MEDICARE	PRE	INTRA	POST
HCPCS	MOD	DESCRIPTION	CODE	PAYMEN	OP	OP	OP
66984		Xcapsl ctrc rmvl w/o ecp	A		0.10	0.70	0.20

Modifier 55 postoperative management only

Modifier 55 is used when a different physician or other qualified health care professional performs the postoperative management. This should be billed using the same date of service as the surgery.
The billing for the surgical CPT with modifier 55 will include all related office visits within the postoperative period of the surgery. When a claim is received with modifier 55, the payment for the services will be calculated to include Post-op % only from the Medicare Physician Fee Schedule.

Fee schedule amount for the code x post-op %

Example:
CPT 66984 with modifier 55

- The total OHA Non-facility rate of $405.65
  $405.65 x 0.20 =
  $81.13 is the allowed amount for the services

		2024 National Physician Fee Schedule Re					
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		RELEASED 12/14/2023					
				NOT USED FOR			
HCPCS	MOD	DESCRIPTION	STATUS CODE	MEDICARE PAYMEN	PRE OP	INTRA OP	POST OP
66984		Xcapsl ctrc rmvl w/o ecp	A		0.10	0.70	0.20

Additional scenarios

In the rare instance that preoperative management is performed and billed separately from operative and postoperative care, modifier 56 should be used and billed in the same fashion as modifier 55.
The surgical care claim (with modifier 54) will be reduced by the percentage payable as pre-op % of the Medicare Physician Fee Schedule.

In the case that postoperative care is split between provider groups, the postoperative amount may also be split based on the number of days of postoperative care being rendered by each provider group.

Example:
Provider group A oversaw 9 days of postoperative care for a 90-day surgery before transferring the patient to provider group B for the remainder of the 90 days.

Postoperative care total will be calculated as above when billed with modifier 55. Then the payment amount will be split between provider group A (to receive 9/90 or 10%) and provider group B (to receive 81/90 or 90%).

References

Oregon Secretary of State Administrative Rules 410-140-0300 Post-Operative Care
54 - JF Part B - Noridian (noridianmedicare.com)
55 - JF Part B - Noridian (noridianmedicare.com)