LifeWise Assurance Company

Payment Policy

cmi_051720

Title	**Modifier 54, 55, 56-Surgical Care Only/Postoperative Management Only/Preoperative Management Only**		
Number	**CP.PP.184.v2.6**		
Last Approval Date	09/04/24	**Original Effective Date**	01/01/05
Replaces	N/A		
Cross Reference	*Global Surgery*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes services appended with modifier 54, 55, or 56 that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company, and Premera Blue Cross HMO lines of business and products.

Policy	The Plan recognizes modifiers 54, 55, and 56 appended to a service to indicate when a physician or other qualified healthcare professional furnishes only **part of a global surgical package** and relinquishes the other portion(s) of the surgical package to another physician or other qualified healthcare professional **belonging to a different practice**.
	
	These modifiers are applicable to codes in the current CMS National Physician Fee Schedule (LINK) that include global periods of 10 or 90 days. These modifiers **do not apply** to assistant surgeon services:
	
	• **Modifier 54 – Surgical Care Only**
	  ○ Used to indicate when one physician or other qualified healthcare professional performs the **surgical care only** and another physician or other qualified healthcare professional performs the pre-operative or post-operative care, **each belonging to a different practice.**
	  ○ Services rendered by emergency room providers who perform a minor or major global surgical procedure (10 and 90 days respectively) in the ER should append this modifier to their services since the member is not expected to receive postoperative care in the ER setting.
	  ○ Reimbursement will be 70% of the provider's applicable Fee Schedule allowed amount.
	• **Modifier 55 – Postoperative Management Only**
	  ○ Used to indicate when one physician or other qualified healthcare professional performs the **post-operative management only** and another physician or other qualified healthcare professional performs the surgical care, **each belonging to a different practice**.
	  ○ Reimbursement will be 20% of the provider's applicable Fee Schedule allowed amount.
	• **Modifier 56 – Preoperative Management Only**
	  ○ Used to indicate when one physician or other qualified healthcare professional performs the **pre-operative management only** and

	another physician or other qualified healthcare professional performs the surgical care, **each belonging to a different practice**. o Reimbursement will be 10% of the provider's applicable Fee Schedule allowed amount. Reimbursement for services appended with modifiers 54, 55, 56 will be adjusted per the percentages noted above to reflect the specific **component** of surgical care rendered. It is the responsibility of each of the physicians or other qualified healthcare professionals to ensure that the billings accurately reflect the **portion of the global services** the physician or other qualified healthcare professional performed. Documentation in the patient's medical record should detail the specific services rendered for each portion of the global services. Any billing discrepancies should be worked out between the physicians or other qualified healthcare professionals involved in the patient care for performance of the global procedure.	
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined at Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.	
Exceptions	N/A	
Laws, Regulations & Standards	None	
References	• American Medical Association Current Procedural Terminology (AMA/CPT) codebook • Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS)	
Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	09/04/24; 12/13/23; 01/17/23; 04/08/22; 04/16/21; 04/30/20; 05/24/19; 06/05/18; 08/11/17; 09/14/16; 11/15/15; 11/23/14; 01/13/13; 02/05/12; 02/09/11; 01/27/11; 02/12/10; 03/24/09; 06/16/08; 05/13/07; 04/11/06; 02/28/06; 08/29/05; 07/30/04	
Version History	06/05/18	Annual Review; no changes
	05/24/19	Annual Review, no changes
	04/30/20	Added clarification that the documentation in the patient's medical record should document the portion of the global procedure rendered by each provider
	04/16/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms.

		Inserted LINK to the CMS National Physician Fee Schedule in the Policy section.
	04/08/22	Annual review; no changes
	01/17/23	Inserted the phrase “or other qualified healthcare professional” as a potential provider of services. Added the second bullet under Modifier 54
	12/13/23	Annual review; no changes
	09/04/24	Annual review; no changes