Billing & Coding Guidelines – Post-Surgical Co-Management

When a physician performs a patient’s surgical services and another physician provides the preoperative and/or postoperative management, an agreement to share the “global” service package may be obtained.

Global Component Modifiers used when submitting co-managed claims

**Modifier 54 - Surgical Care Only** – The surgeon appends modifier 54 to his/her claim to indicate shared services. The surgeon’s payment is then limited to the pre-operative and intra-operative components of the fee schedule amount.

**Modifier 55 - Post-Operative Management Only** – The physician sharing care appends modifier 55 to his/her claim. The Physician payment is then limited to the post-operative component of the fee schedule amount. Typically, 20% of the allowed amount of the surgery.

If the physician who performs surgery relinquishes care after the surgery, he/she need only show the date of surgery and bill the surgical procedure code with modifier 54.

If the surgeon continues to care for the patient for some period following the surgery, he/she should bill the date of surgery, the surgical procedure code with modifier 54 (indicating surgery only) and a separate line item with the date of surgery, surgical procedure code with modifier 55 (indicating post-operative care). In this case, it would be necessary to show the dates during the post-operative period for which he/she was responsible. This should be indicated in Item 19 on the CMS-1500 claim form or the electronic equivalent.

**Billing Post-Operative Care Only**

When billing only for post-operative care, the post-operative care will be paid according to the number of days the physician was responsible for the patient’s care. The date on which care was assumed must be shown on the claim. When the surgeon and the physician providing, the post-operative care agrees on the transfer of care, it must be documented in the patient’s medical record. This agreement may be in the form of a letter or a surgical summary. If providing care for the complete 90-day global period, reimbursement will typically be 20% of the allowed surgical fee.
**Surgeon Billing:**

*Physician 1:* Dr. Brown performed cataract surgery on 08/05/016 and provided no post-operative care. Care is transferred to Dr. Robinson at the one day post-operative date.

*Physician 2:* Dr. Robinson assumed responsibility for the post-operative care on 08/06/2016.

**Dr. Brown (physician 1) would bill as follows: (Surgeon)**

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>CPT/Modifier(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>08052016</td>
<td>66984 54 RT</td>
</tr>
</tbody>
</table>

Dr. Brown must indicate on the claim with modifier 54 that only the surgical component was provided.

Note: If modifier 54 is not appended to the surgical claim, the post-operative claim will be denied for services provided elsewhere.

**Dr. Robinson (physician 2) would bill as follows:**

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>CPT/Modifier(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>08052016 (same date as the surgery)</td>
<td>66984 55 RT</td>
</tr>
</tbody>
</table>

Dr. Robinson must indicate on the claim responsibility for the patient’s post-operative care (e.g., Assumed care from 08/06/2016 to 11/03/16). This information should be provided in box 19 on the CMS-1500 claim form or in the electronic equivalent.

The unit/days reported in box 24G would be equal to 1 unit on the claim submission if the full 90 days of care was assumed. (Some payers prefer 90 days vs. 1 unit, double check individual payer preferences/policy)

(Note: NGS Medicare MAC will only accept “90” units (or the actual number of days you co-managed the patient). In this situation, you would divide the number of days you co-managed the patient by your total co-management fee and bill that dollar amount as a “Per-day” amount. States Medicare carriers may vary)

**It is very important for the surgeon to bill with modifier 54 if he/she is not going to provide the full period of post-operative care.** If the surgeon fails to append modifier 54, the claim for the post-operative care (modifier 55) will be denied. The surgeon will have to go back and corrected the claim, before the post-operative claim can be paid.
Billing Tips:

Include the following information on your CMS-1500 claim form or electronic equivalent:

[Box 17] Surgeon’s name

[Box 17B] Surgeon’s NPI number

[Box 19] Assuming care: Enter your post-op date span
- Starting with the date care was assumed
- Ending exactly 90 days from the day of surgery (using global calculator recommended) https://www.timeanddate.com/date/dateadd.html
**The most common claim denials for ODs providing post-op care is miscalculation of the date span.

[Box 21] Enter the diagnosis code used for the surgery as noted on the post-op letter provided by the surgeon

[Box 24A] Date of surgery (not the first day seen in OD office)

[Box 24B] CPT code as billed by the surgeon. 55 modifier, surgery eye (RT or LT)

[Box 24G] List as 1 Unit or 90 days depending on payer preference/policy

Sample Claim – Physician billing for post-operative care

<table>
<thead>
<tr>
<th>17. NAME OF REFERREING PROVIDER OR OTHER SOURCE</th>
<th>17a. NPI</th>
<th>16. HOSPITALIZATION DATED RELATED TO CURRENT SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN Stephen Robinson, MD</td>
<td>XXXXXXX</td>
<td></td>
</tr>
<tr>
<td>Assumed Care 08 / 06 /2016 until 11 / 03 /2016</td>
<td>XXXXXXX</td>
<td></td>
</tr>
<tr>
<td>Diagnosis or Nature of Illness or Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H25.11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note:

When providing care for patients under 65 and not on a Medicare or Medicare replacement plan verifying eligibility of coverage of co-managed benefits is strongly recommended. Not all commercial payers offer this coverage for beneficiaries under 65.
Modifiers During Postoperative Period

24 – Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period.

Modifier 24 is added to the selected E/M and eye code to identify the service rendered by the same provider as unconnected and distinct from other services in the patient’s postoperative period.

Guidelines state that modifier 24 should be reported with E/M services provided in the postoperative period of a major or minor procedure (i.e., those with a 10 or 90-day follow-up respectively) only if the E/M service is not related to the surgical procedure.

Sample Claim

79 – Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period.

Modifier 79 is used to indicate that the performance of a procedure during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79.

Modifier 79 reports procedure/service (other than an office visit) performed by the provider as unrelated to the original procedure. When this modifier is used a different diagnosis code from what was reported with the original procedure should be reported. Failure to use modifier 79 when appropriate may result in a denial of the subsequent surgery.

Sample Claim – Second surgery perform in the global period