



## *Modifier 55 Fact Sheet*

### Definition:

- Indicate a physician, other than the surgeon, is billing for part of the outpatient postoperative care.
- Also, used by the surgeon when providing only a portion of the post-discharge post-operative care.

### Appropriate Usage:

- Billed for the surgeon and the physician, other than the surgeon, who furnished a portion of the outpatient postoperative care
- Append to the procedure code that describes the surgical procedure performed that has a 10 or 90-day postoperative period.
- The claim must show the **date of surgery as the date of service**.
- Indicate the date of care assumption and relinquished in Item 19 of the CMS-1500 claim form or the electronic equivalent.
- After the physician has seen that patient, submit a bill for the period beginning with the date on which they assumed care.
- When two different physicians share in the postoperative care, each bills for their portion-reporting modifier 55 and indicating the assumed and relinquished dates on the claim.

### Inappropriate Usage:

- Appending to a surgical code without 10 or 90-day post op period
- Appending to an E/M procedure code
- Appending to assistant at surgery services
- Appending to Ambulatory Surgical Center's facility fees
- When the transfer of care occurs immediately after surgery with inpatient care provided, the receiving physician should bill subsequent hospital care codes. Payment will be allowed if they are not the same physician.\*
- Do not report modifier 52 along with modifier 55 when furnishing only part of the postoperative care (MN providers only).

### Facts

- The physician furnishing postoperative care must keep a copy of the written transfer agreement in the beneficiary's medical record.
- Medicare payment is limited to the same total amount as would have been paid if one physician provided all of the care, regardless of the number of physicians providing care.



Example:

The surgeon relinquished care to another physician for the postoperative, post-discharge. That physician bills for the time frame that they are covering the patient.

|                                                                                       |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  |                                                          |  |                       |  |           |  |                          |  |  |  |
|---------------------------------------------------------------------------------------|--|--------------------|--|------------------|--|-----|--|-------------------------------------------------------------------|--|-----------|--|----------|--|----------------------------------------------------------|--|-----------------------|--|-----------|--|--------------------------|--|--|--|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE                                        |  |                    |  |                  |  |     |  |                                                                   |  | 17a.      |  | 17b. NPI |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES    |  |                       |  |           |  |                          |  |  |  |
| 19. RESERVED FOR LOCAL USE                                                            |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  | FROM                                                     |  | TO                    |  |           |  |                          |  |  |  |
| Assumed care 2/7/05 Relinquished care 3/15/05                                         |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  |                                                          |  |                       |  |           |  |                          |  |  |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to item 21.1) |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  | 20. OUTSIDE LAB?                                         |  |                       |  |           |  |                          |  |  |  |
| 36616                                                                                 |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  | <input type="checkbox"/> YES <input type="checkbox"/> NO |  |                       |  |           |  |                          |  |  |  |
| 22. MEDICAID RESUBMISSION CODE                                                        |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  |                                                          |  |                       |  |           |  |                          |  |  |  |
| 23. PRIOR AUTHORIZATION NUMBER                                                        |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  |                                                          |  |                       |  |           |  |                          |  |  |  |
| 24. A.                                                                                |  | DATE(S) OF SERVICE |  | B.               |  | C.  |  | D.                                                                |  | E.        |  | F.       |  | G.                                                       |  | H.                    |  | I.        |  | J.                       |  |  |  |
|                                                                                       |  | From To            |  | PLACE OF SERVICE |  | EMG |  | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) |  | DIAGNOSIS |  | CHARGES  |  | DAYS OR UNITS                                            |  | EPISODE (Family Plan) |  | ID. QUAL. |  | RENDERING PROVIDER ID. # |  |  |  |
|                                                                                       |  | MM DD YY MM DD YY  |  | SERVICE          |  |     |  | CPT/HCPCS MODIFIER                                                |  | POINTER   |  | \$       |  |                                                          |  |                       |  |           |  |                          |  |  |  |
| 1                                                                                     |  | 02 01 06           |  | 11               |  |     |  | 66984 55                                                          |  | 1         |  | 69.00    |  | 001                                                      |  |                       |  | NPI       |  | 1234567890               |  |  |  |
| 2                                                                                     |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  |                                                          |  |                       |  | NPI       |  |                          |  |  |  |
| 3                                                                                     |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  |                                                          |  |                       |  | NPI       |  |                          |  |  |  |

The date for relinquish and assumption is not included.

|                                                                                       |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  |                                                          |  |                       |  |           |  |                          |  |
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| 19. RESERVED FOR LOCAL USE                                                            |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  | FROM                                                     |  | TO                    |  |           |  |                          |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to item 21.1) |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  | 20. OUTSIDE LAB?                                         |  |                       |  |           |  |                          |  |
| 36616                                                                                 |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  | <input type="checkbox"/> YES <input type="checkbox"/> NO |  |                       |  |           |  |                          |  |
| 22. MEDICAID RESUBMISSION CODE                                                        |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  |                                                          |  |                       |  |           |  |                          |  |
| 23. PRIOR AUTHORIZATION NUMBER                                                        |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  |                                                          |  |                       |  |           |  |                          |  |
| 24. A.                                                                                |  | DATE(S) OF SERVICE |  | B.               |  | C.  |  | D.                                                                |  | E.        |  | F.       |  | G.                                                       |  | H.                    |  | I.        |  | J.                       |  |
|                                                                                       |  | From To            |  | PLACE OF SERVICE |  | EMG |  | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) |  | DIAGNOSIS |  | CHARGES  |  | DAYS OR UNITS                                            |  | EPISODE (Family Plan) |  | ID. QUAL. |  | RENDERING PROVIDER ID. # |  |
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| 1                                                                                     |  | 02 01 06           |  | 21               |  |     |  | 66984 55                                                          |  | 1         |  | 69.00    |  | 001                                                      |  |                       |  | NPI       |  | 1234567890               |  |
| 2                                                                                     |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  |                                                          |  |                       |  | NPI       |  |                          |  |
| 3                                                                                     |  |                    |  |                  |  |     |  |                                                                   |  |           |  |          |  |                                                          |  |                       |  | NPI       |  |                          |  |