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Global Surgery Changes Take Effect Jan. 1, With More Leeway, Payment for Post-Op Care

By Nina Youngstrom

Starting Jan. 1, surgeons will have more leeway to hand off post-op care to other physicians, who will be paid extra for taking over. A new add-on code (G0559) boosts physician payments for providing the back end of the global surgery package (GSP), but not by much, and there are considerable requirements attached.

The transfer-of-care relaxation and new code affect the GSP, which is a soup-to-nuts payment for surgery—pre-op management, the surgery itself and post-op management. CMS will soon allow the GSP to be split among physicians when there's an informal but expected transfer of care and add dollars for the physician who does post-op management, said Brian Raabe, a manager at PYA.

But G0559 only pays $8.50, said attorney and certified coder Richelle Marting, director of managed care contracting at North Kansas City Hospital in Missouri. "There seem to be so many compliance hurdles to using this code for a maximum of $8.50 one time in a post-op period," she noted.

Until CMS finalized the changes in the 2025 Medicare Physician Fee Schedule (MPFS) rule, CMS only allowed formal, planned and documented transfers of care from the surgeon to another physician or nonphysician practitioner (NPP) for post-op care.[1] When the GSP is split into separate components in a formal transfer of care, surgeons and other physicians report their respective modifiers with the same surgical code on their claims, Raabe said at a Dec. 4 webinar sponsored by PYA. Both physicians bill for the surgery, with the surgeon adding modifier 54 (surgery only) and the physician who performs the post-op services adding modifier 55 (post-op management only). Modifier 56 is for pre-op care if someone else provides it.

There's nothing new about the modifiers per se, but CMS revised the transfer-of-care policy with respect to them. Next year, modifier 54 may be reported when there's an informal, nondocumented, but expected transfer of care between the physicians, Raabe explained. CMS used the term "broadening the applicability of the modifier," but he thinks of it more as a relaxation. For the informal transfer of care, the surgeon will still bill the surgery code with modifier 54, but the physician providing post-op services after hospital discharge will bill an evaluation and management code (99202 to 99215) with G0559 for the initial post-op visit. A November 2024 MLN Booklet notes that "Providers supplying minor emergency department follow-up services should bill the level E/M code without a modifier."[2]

Where the pre-op modifier fits in is a bit fuzzy because there was nothing about it in the MPFS rule. "It's assumed when the physician bills modifier 54 and they transfer care, they also provided pre-op care and are paid accordingly," Raabe said. CMS's silence may indicate something is in the works with respect to a stand-alone payment for the surgery, said Valerie Rock, a principal at PYA. CMS has historically told providers not to bill the pre-op modifier, but it "may be getting ready to change the way they're paying," Rock said.

Is Add-On Code About Data Collection?

On the other side of the patient hand-off is the extra payment for post-op management when there's no formal

transfer of care, Raabe said. The intent of the add-on code is to reflect the additional time, complexity and costs of taking on the patient after a surgery performed by a different physician. It's only reported by the physician who performs the post-op care.

The definition of the code is: "Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice), and is of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care."

It could come up in any number of situations, such as patients having procedures while out of town and then returning to their primary care physician for post-op management or maybe just disliking the surgeon and preferring to have post-up care elsewhere, Marting said. But Medicare isn't paying a lot above the evaluation and management CPT code for G0559 considering the amount of work required, Marting said. It includes, according to the MPFS rule:

- "Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation.
- "Research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty).
- "Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately.
- "Communicate with the practitioner who performed the procedure if any questions or concerns arise. (List separately in addition to office/outpatient evaluation and management visit, new or established)."

Because the payment is low, Marting suspects the new code is "part of CMS's data collection efforts on the post-op period." In 2017, CMS started collecting data on Part B claims, with a focus on post-op E/M services, Raabe said. CMS was informed by the HHS Office of Inspector General, which found that providers were performing fewer post-op visits than accounted for during the GSP valuation process.

Questions remain about how G0559 fits in with another add-on code, G2211. "Nothing in the final rule says you can't bill them together," Rock noted. "You'd assume there are different reasons to bill for the code." G2211, which was activated in 2024, is extra payment for "medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition." Physicians and NPPs are permitted to bill G2211 with their office or outpatient evaluation and management visits (99202-99205 and 99211-99215) if the ongoing care describes a longitudinal relationship between the practitioner and the patient.

"Both seem billable, but we want to put the radar up for that to be potentially edited in the future," Rock noted.

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1 Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments, 89 Fed. Reg. 97,710 (Dec. 9, 2024), https://bit.ly/3OYAcmX.
2 Centers for Medicare & Medicaid Services, "Global Surgery," MLN907166, November 2024, https://go.cms.gov/3ZKbzzq.