Strategies for Improving Global Surgery Payment Accuracy

Q: What are the transfer of care modifiers, how are they billed, and what modifiers are billed when a practitioner performs some or all of the global surgical package and post-operative care?

A: There are three transfer of care modifiers that account for different payment amounts depending on which part of the procedure was performed. The three modifiers are: modifier -54 (to be appended to the global package when the practitioner provides surgical care only; modifier -55 (to be appended to the global package when the practitioner provides post-operative management only); and modifier -56 (to be appended to the global package when the practitioner provides pre-operative management only). We note that for Calendar Year (CY) 2025, we are only finalizing to broaden the applicability of transfer of care modifier -54 for 90-day global packages.

Q: If the practitioner intends to perform the procedure, including all pre-operative, intra-operative, and post-operative care, what code and modifier(s) should be billed?

A: If the billing practitioner intends to perform all elements of the service, there would be no change in billing rules. The global code would be billed without a modifier, as the practitioner who performs the pre-operative, intra-operative, and post-operative care may receive the full payment for the global package.

Q: What code and modifier(s) should the practitioner who performed the surgical procedure bill if they are not planning to see the patient for post-operative care?

A: The practitioner who performed the procedure and who does not intend to see the patient for post-operative care should bill the appropriate global package with the -54 modifier (surgical care only). This includes, but is not limited to, when there is a formal, documented transfer of care as under current policy or an informal, non-documented but expected, transfer of care.

Q: What code should be billed when a practitioner sees a patient for a post-operative visit and they did not perform the procedure, and who can bill the code?

A: We created a new code, HCPCS code G0559, beginning in CY 2025, that may be billed by the physician or practitioner who furnishes the post-operative office/outpatient E/M visit when the surgical procedure portion of a global package service is performed by another practitioner in the case of a 90-day post-operative visit.

Q: Who can bill the add-on code, and is there a frequency limitation?

A: The add-on code (HCPCS code G0559) can only be billed by a practitioner who did not perform the actual procedure and is not in the same group practice as the surgeon. HCPCS code G0559 may only be billed once during the 90-day post-operative period.

Q: Can practitioners in the same group practice or specialty as the practitioner who performed the surgery bill the add-on code (HCPCS code G0559)?

A: Practitioners in the same group practice as the practitioner who performed the surgery cannot bill HCPCS code G0559. Practitioners who are of the same specialty as the practitioner who performed the surgery may bill HCPCS code G0559 if they furnish the post-operative care.

Q: What should the practitioner who did not perform the surgical procedure document to support the modifier being billed?

A: Documentation in the medical record must support that the E/M visit was related to a post-operative visit furnished during the 90-day period following a procedure.

Q: Can the add-on code be billed with a low-level E/M visit that may not require the presence of a physician or other qualified health care professional?

A: No. The billing practitioner must personally perform the E/M post-operative visit in order to bill the add-on code.