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# EXPANDED TRANSFER OF CARE POLICIES IN RETINA

Here's what's old and how to implement what's new.

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Beginning in 2025, the Centers for Medicare and Medicaid Services broadened their policies related to transfer of care during the global period.[1] Their goal is to improve the accuracy of the global surgery payment and tracking processes.

## WHAT'S THE SAME?

There is no change to the documentation requirements or coding for a formal, documented transfer of care agreement, or comanagement. Primarily reported with cataract-related procedures, ophthalmology uses a few transfer of care modifiers, including:

- Modifier -54: Surgical care only
- Modifier -55: Postoperative management only

When an external physician is the sole provider of preoperative care, modifier -56 is used; however, it is rarely used in ophthalmology.

Formal comanagement arrangements are initiated by patient request. For example, a surgical patient might request such an arrangement if they live 2 hours from the surgical site and wish to minimize their travel time for postoperative visits. Both the patient and the nonoperating practitioner must agree to the arrangement.

After surgery, there is a formal transfer of care documented by the surgeon. This should include the date of transfer and relevant clinical information.

The coding and claim submission would reflect this arrangement to accurately report the global days provided. For example, if a patient is comanaged for a vitrectomy (CPT code 67036) performed on April 1 in the right eye and the surgeon provided 7 of the 90 days of postoperative care before transferring care, the surgeon's claim should be reported as:

- 67036 -54-RT
- 67036 -55-RT – prorated fee
  - Report prorated date range in item 19: 4/2/25–4/8/25

The comanaging clinician's claim should be reported as:

- 67036 -55-RT – prorated fee
  - Report prorated date range in item 19: 4/9/25–6/30/25

There are additional compliance, ethical, and legal pitfalls to avoid related to comanagement. AAO members can explore additional guidance in the AAO's Comprehensive Guidelines for the Co-Management of Ophthalmic Postoperative Care.[2]

## WHAT'S NEW?

When the retina specialist provides only the surgical component of the global package, modifier -54 must be reported with the CPT code for the surgery. This is an expansion from the previously established formal comanagement agreement, which now includes an informal, nondocumented but expected transfer of care.

If, for example, the patient notifies the surgeon that they will be moving out of state and will not be coming back for postoperative care, modifier -54 is required for the surgical claim. There are no requirements for the use of modifiers

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-55 and -56 for external providers in these cases, which continue to be used when there is a formal, documented transfer of care established prior to surgery.

## E/M ADD-ON CODE

Medicare also implemented a new E/M add-on code, HCPCS code G0559, which is defined as: Postoperative 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 the same or 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.

The reimbursement for this code captures the additional time and resources it takes to provide postoperative care when the retina specialist themself did not perform the surgery or was not involved in a formal, documented transfer of care agreement.

There are four elements that must be confirmed through documentation when reporting this code:

1. Request and review the surgical operative report and other chart documentation to confirm relevant clinical details.
2. For a procedure outside the physician's specialty, research the procedure, expected postoperative care, and possible complications.
3. Document the examination and postoperative progression.
4. Communicate the patient's status to the surgeon who performed the procedure.

This add-on code was designated by Medicare and is associated with a total relative value unit of 0.27, which translates to a national average payment of $8.73.

HCPCS code G0559 should not be reported:

- by the surgeon who performed the surgery,
- by any provider in the same practice as the surgeon,
- by the surgeon or comanaging physician when a formal agreement has been executed,
- more than once during the 90-day global period,
- with an eye visit code (92002, 92012, 92004, 92014), or
- to any payers other than Medicare Part B, unless they have a published coverage policy.

### G0559 Case Study

A Medicare Part B patient who had a retinal detachment repair (CPT code 67108) 1 month ago by a retina specialist in a different state presents with visual disturbances. The retina specialist seeing the patient now requests and reviews the patient's chart notes and the operative report. The provider evaluates the patient, documents their postoperative status, and sends a letter to the surgeon.

This office visit meets all the requirements for HCPCS code G0559 and should be billed with an appropriate level of E/M.

The patient returns in 1 week for a follow-up visit. G0559 should not be reported for this encounter, as it can only be billed once during the entire 90-day global period.

## STAY IN THE KNOW

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1. Medicare physician fee schedule final rule summary: CY 2025. CMS. Accessed April 4, 2025. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.cms.gov/files/document/mm13887-medicare-physician-fee-schedule-final-rule-summary-cy-2025.pdf
2. Comprehensive Guidelines for the Co-Management of Ophthalmic Postoperative Care. AAO. September 7, 2016. Accessed April 4, 2025. www.aao.org/education/ethics-detail/guidelines-comanagement-postoperative-care

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