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CMS Plan to Revise Global Surgeries 'Could Be a Sea Change'; Focus is on Transfer of Care

By Nina Youngstrom

Almost a decade after its changes to the global surgery package (GSP) were foiled by Congress, CMS has proposed different changes, although they aren't quite as sweeping. CMS now has plans to revise its transfer-of-care policy in what seems to be a recognition that the physician performing the procedure often doesn't provide post-operative care, according to the proposed 2025 Medicare Physician Fee Schedule (MPFS) rule published in the *Federal Register* July 31.[1] A related proposal would create an add-on code for physicians who provide post-op services when there's an unexpected transfer of care.

"This could be a sea change in how we do global surgeries," said Valerie Rock, a principal with PYA.

The rule would allow the proceduralist (i.e., the physician performing the procedure) to hand off post-op care to another physician when there's an expected transfer of care but no formal agreement or documentation, said Brian Raabe, a manager at PYA. Currently, transfers of care are allowed under the GSP when they're expected but also formal and documented. Both scenarios require the continued use of transfer-of-care modifiers: 54 for surgical care only; 55 for post-operative management only; and 56 for pre-operative management only. (Rock recommends stakeholders ask CMS for clarification during the comment period about pre-operative modifier use because the industry interprets the Medicare manual to say that modifier 56 wasn't permitted in the transfer of care and that modifier 54 was reimbursed for pre-operative and surgical care).

The MPFS proposal would also reward, in an unexpected transfer of care, the physicians or other qualified health care professionals who take on post-op care. They would be able to bill the new add-on code, GPOC1, in addition to the evaluation and management (E/M) service.

The proposed changes appear to be an attempt to right-size payments for global surgery, which generate soup-to-nuts reimbursement (pre-operative, intraoperative and post-operative services), Rock and Raabe said at a PYA webinar and in interviews. The transfer-of-care revision is also a relaxation of the policy, Raabe said. CMS said it's driven partly by the fact that transfer-of-care modifiers are used inconsistently, except with certain ophthalmology procedures (e.g., cataract surgeries), although the data suggests post-op visits are often performed by someone other than the proceduralists.

'Care Models Are Evolving'

Medicare pays a bundled fee for global surgery in three ways:

- **Zero-day period:** Raabe said this is typically for endoscopy and other minor procedures that don't have pre- or post-op periods; therefore, nothing is separately payable.
- **10-day period:** There's no pre-op period but the 10-day period, begins immediately after the procedure.
- **90-day period:** This includes the day before the surgery and a post-op period of 90 days.

In a 2015 final rule, CMS converted all global surgeries to zero days, putting an end to the GSP concept, Raabe said. The idea was the proceduralist would bill for the surgery using a CPT code "and any services outside of that would be billed by the provider who furnished it," he explained. But Congress killed the CMS change, and the three GSP periods remain.

Two years later, 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 (OIG), which found that providers were performing fewer post-op visits than accounted for during the GSP valuation process. For example, only 4% of post-op services were furnished during the 10-day global period and 38% in the 90-day global period.

"CMS recognized they have been paying for more post-surgical services than are actually occurring regularly," Rock noted. The 2025 proposals are an acknowledgement that GSP payments aren't always accurate because of the way medical care delivery models have changed, Rock and Raabe said. When the GSP was first developed, the surgeon would see the patient through the entire process. "While that can still happen, care models are evolving and it's not always reasonable or necessary for that to be the case," Raabe explained. It might be in the patient's best interest for several providers to be involved in the care.

That's where transfers of care come in. Currently, CMS allows planned transfers of care from the proceduralist to a physician for post-op care when the arrangement is documented. Both physicians bill for the surgery, with the proceduralist adding transfer-of-care modifier 54 (surgery only) and the physician who performs the post-op services adding transfer-of-care modifier 55 (post-op management only). Modifier 56 is appended when the physician does pre-operative services only.

Now, CMS is proposing to allow transfers of care that aren't formal, but expected. For example, patients treated in the emergency room for fractures may have post-op care with a different physician, Rock said.

Add-On Code for Practitioner in Different Practice

The proposed add-on code would increase reimbursement for unexpected transfers of care when physicians bill for post-op care within the 90-day global surgery period. The patient may not want to return to the surgeon for post-op care for personal reasons, for example, or could be out of town during the 90-day period, Rock and Raabe said. The add-on code (GPOC1) reflects the extra time and complexity of resources expected when a physician (or other qualified health practitioner) treats the patient post-operatively after the procedure is performed by a different practitioner from another specialty and/or group practice when there's no formal transfer of care. GPOC1 is reported in addition to the office/outpatient E/M for the post-op service. The add-on code would only be used if the practitioner providing post-op care "is outside the proceduralist's practice," Raabe noted.

From a compliance perspective, Rock suggested that surgery practices consider looking at whether they're providing all global surgery services "because it may be called into question when they're billing the GSP and not providing post-op care. If you have potential risk there—especially when it's documented that the patient will have post-op care handled by another physician group—consider policies and processes to ensure the claim is billed with the surgery-only modifier (54)."

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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. 61,596 (July 31, 2024),

https://bit.ly/3ywY6Bs.