Question of the Month August 2026

Question:

We need clarification on how to code cataract surgery post op visits with medicare advantage plans. In the past, we were filing a 66984. A consultant told us that we should be filing an office visit code for each encounter. Which way is correct? The specific plans are Humana, Wellcare, United healthcare and Blue Cross commercial plans.

Response:

Humana Modifier 54-55-56

https://dctm.humana.com/Mentor/Web/v.aspx?chronicleID=090009298184a1e9&searchID=eee62635-7898-43a6-b8c9-59ffecc5f615&dl=1&exttoken=MDkwMDA5Mjk4MTg0YTFlOXwxNzg1MTcxNTgwfHFVSnFzVzdVYmxISzgyNEdDbStJblo2Z3I1OWNCcU53ZklwTC9CVVJCY1U9

Wellcare (Centene) states they follow Medicare for Modifier 54-55-56 use. This policy discusses their policies.

https://www.ambetterhealth.com/content/dam/centene/policies/payment-policies/CC.PP.040.pdf

UHC Split Surgical Policies

Commercial: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Split-Surgical-Package-Policy.pdf

BCBS Mississippi

https://webstatic.bcbsms.com/pdf/Modifier_Usage_Guide.pdf

I am wondering if the consultant has gotten confused with the code that CMS added for those cases when a formal transfer of care has not occurred? In that case, a provider who, without formal transfer, takes over care, they file the E&M codes that are appropriate and can also file, one time G0559 code.

> **G0559** Post-operative care services furnished by a practitioner other than the one who performed the surgical procedure (or another practitioner in the same group practice).
>
> G0559 and Modifier 54: CMS is finalizing a policy to expand the applicability of the transfer of care modifier 54 to all 90-day global surgical procedures when the provider expects to only provide the surgical procedure itself. The -54 modifier use requirement will include but not be limited to situations where there is a formal and documented transfer of care as under current policy or whether the transfer of care is informal and not documented but is expected. The goal of this policy is to provide CMS with accurate information regarding the manner in which global services are typically provided. G0559 is a new add-on code used for post-operative care services furnished by a practitioner other than the one who performed the surgical procedure (or another practitioner in the

same group practice) *when a formal transfer of care does not occur* and is intended to more appropriately account for the time and resources involved in these post-operative follow-up visits provided (without a formal transfer of care). This code should be billed with an office or other outpatient evaluation and management (E/M) visit and only where there has not been a formal transfer of care, for new or established patients, and is only be billed once during the 90-day global period. This code encompasses tasks such as:

- Reviewing surgical notes full understanding of any unique aspects of procedure and potential complications possible
- Any research that might be required to understand the expected postoperative recovery (if outside your specialty)
- Examine the patient to determine if the postoperatively recovery is progressing normally
- Communicate with the surgeon in the event of any concerns or questions arising from the surgery occur

Please note that CMS has not made any changes for the use of Modifier -55 and should be billed exclusively in cases where there is a documented formal transfer of care between the surgeon and the Optometrist.

Otherwise, there is no new guidance that I can find that would account for the information they seem to be using. Humana does not really have commercial plans anymore. Ambetter under Wellcare (Centene) would be the closest they have to a commercial plan.