

Coordinating Post-Operative Care with Ophthalmic Surgeons

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A few questions have recently been asked about filing for cataract and other surgery post-operative care. This article is meant as a review of the acceptable post-operative care transfers per CMS. Please review the resources at the end of this article for more information.

First, providers should avoid any perception of activities that CMS could interpret as “illegal” such as:

- Automatic referrals back to the referring optometrist for post-operative care – consider each case separately
- Referring optometrist accepting an extra fee from the surgeon to co-managers for advanced technology IOLs above the standard Medicare post-operative care fee
- Optometrists accepting gifts and Inducements for patient referrals such as free continuing education, expensive dinners, or lavish entertainment
- Not allowing patients the option of choosing their own post-operative provider

Second, per CMS, the guidelines for when acceptable co-management services can occur are as follows:

- Patient specifically requests the optometrist for post-op care
- Co-management is clinically appropriate per the surgeon’s determination
- Any co-management fees paid are appropriate for the actual services performed
- Surgeons must ensure that the post-operative provider is qualified

A Written Agreement is between the surgeon and the co-managing provider must be created to designate the shared responsibilities of each for the patient’s post-operative care. This agreement must be signed by both parties and each must retain a copy of the transfer of care document. Only once the surgery has been completed can the actual transfer of care date be determined. There must be clear communication and adherence to guidelines established prior to the surgery. The patient must acknowledge and agree to the transfer of care when clinically appropriate as determined by the surgeon. Each Transfer of Care Document should include the following:

- Date of surgery
- Surgeon’s name and NPI
- Eye that was operated
- Specific ICD-10 diagnosis code reported by the surgeon
- Specific CPT® surgical code reported by the surgeon
- Specific date of transfer to the co-managing doctor
- Any discharge instructions relevant to the case

Cataract surgery is considered to be a major surgery with a 90-day global period. The day of surgery is considered day 0. Preoperative care is valued at 10%, the operative care is valued at 70% and the post-operative care is valued at 20% of the total Medicare allowable fee. Providers will be paid a proportionate amount for the post-operative care performed. Providers can only bill Medicare for post-operative care once the initial visit has occurred.

Submitting the claim for post-operative care:

- The date of surgery = the date of service
- Report date care was assumed and date post-operative care ends (typically day 90) and the number of post-operative care days in Block 19 of the CMS 1500 form (or the electronic equivalent)
- The ICD-10-CM code, the CPT® code with the -55 modifier + eye modifier (RT or LT) must match the surgical claim
- Report the number of units as “1” with the place of service of “11” for the office
- Report post-operative care as your usual and customary fee set for this service and Medicare will compute the appropriate proportion of the 90-day global period for the co-management of the services
- The co-managing provider to must send reports to the surgeon following each visit during the global period and the clinical documentation must reflect the work performed by the co-managing provider
- If a second eye surgery is performed within the post-operative period of the first eye, use the -79 modifier in addition

- A refraction (92015) should be charge when the patient is ready and the final spectacle prescription should be given to the patient and include the date(s) of cataract surgery

If an advanced technology intraocular lens is chosen, the patient's written consent is required and the provider should describe the additional work to be performed or the additional visits required to achieve a satisfactory outcome. An ABN must be in place and the co-managing provider should **independently** determine the appropriate professional fee to provide additional necessary post-operative care required.

RESOURCES

LCD: Complex Cataract Surgery - <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=35091>

Article: Complex Cataract Surgery - <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56615&ver=36>

Global Surgery Calculator - <https://www.novitas-solutions.com/webcenter/portal/MedicareJH/GlobalSurgeryCalc>

Post-operative co-management, modifiers 54 and 55 - <https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00101754>

Provider specialty: Global surgery page - <https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00134386>

MLN Global Surgery: <https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf>

Co-management and OIG-2003: [Co-Management Under Scrutiny | Gordon Feinblatt LLC](#)

CMS Strategies Global Surgery Payment and G0559: <https://www.cms.gov/files/document/faq-strategies-improving-global-surgery-payment-accuracy.pdf>