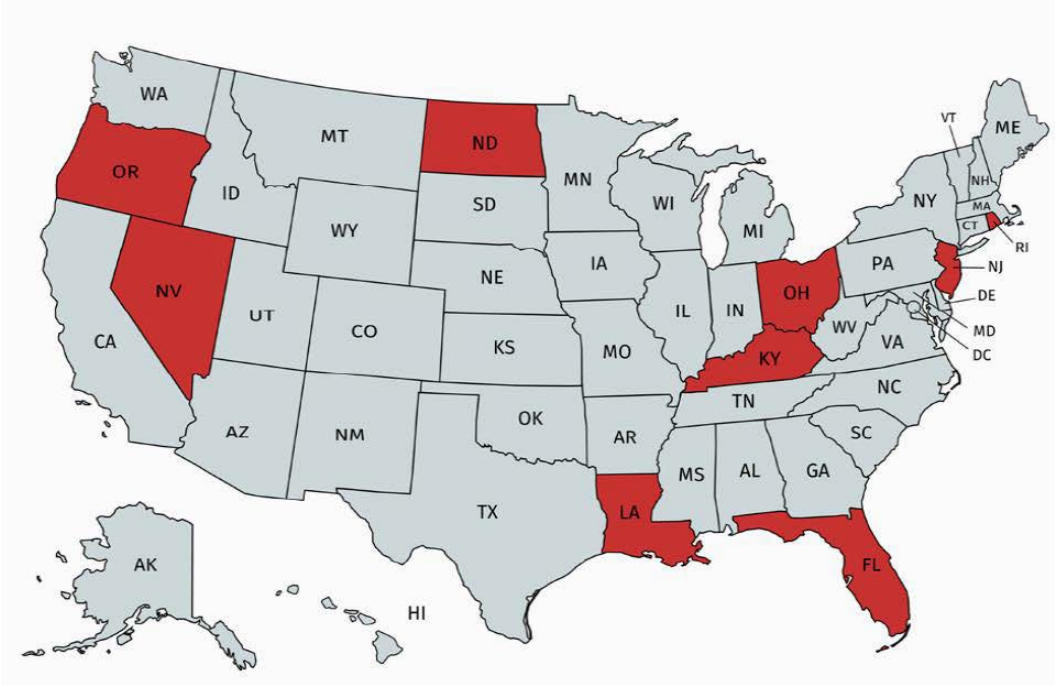
The Society of Thoracic Surgeons

2017 Medicare Claims-Based Reporting Requirements for Postoperative Visits

(*Updated June 23, 2017*)

The Centers for Medicare & Medicaid Services (CMS) has expressed concern about the accuracy of valuation for 10- and 90-day global surgical CPT® codes, specifically as they relate to postoperative visits included in those payments. Put simply, CMS is worried that postoperative visits for 10- and 90-day global surgical procedures aren't occurring. In order to better understand the valuation of these codes, CMS has implemented a new claims-based reporting requirement that will help it ascertain the ***number of postoperative services*** being provided within the 10- and 90-day global payment for certain surgical procedures. This mandatory data reporting applies to surgeons in nine states—Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island.



Implementation Date: The new reporting requirements are for postoperative services (see affected codes on the next page) related to **procedures performed on or after July 1, 2017**; however, CMS has encouraged physicians to begin postop visit reporting before July 1.

Affected Practices: The new reporting requirement is limited to *practices of 10 or more practitioners*. CMS defines a practitioner as a physician or qualified non-physician practitioner (e.g., nurse practitioner, physician assistant) who furnishes services as part of a practice. All practitioners do not necessarily need to share the same physical address to be considered part of the same practice. Note that the reporting requirements apply to all practices that otherwise meet the criteria, including teaching hospitals and physicians.

Applicable Global Codes: CMS has limited the reporting requirement to those Medicare services that are "reported annually by more than 100 practitioners and are reported more than 10,000 times or have allowed charges in excess of $10 million annually." In January, CMS published the list of 293 codes to which the requirement will apply. Physicians should review the complete list of codes and identify any that are performed by their practices.

The major cardiothoracic surgery codes included on the list are:

CPT Code	Descriptor
32480	Removal of lung, other than pneumonectomy; single lobe (lobectomy)
32663	Thoracoscopy, surgical; with lobectomy (single lobe)
33405	Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring
33430	Replacement, mitral valve, with cardiopulmonary bypass
33533	Coronary artery bypass, using arterial graft(s); single arterial graft*
33860	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh

*It is important to remember that code 33533 (CABG arterial single) includes all coronary artery bypass surgeries in which a single arterial graft was used (e.g., CABG using LIMA and single vein graft, LIMA and two vein grafts, LIMA and three vein grafts) since the addition of any vein graft bypasses are XXX codes, i.e., "add-on" codes to the 33533.

While CMS *requires* practices in the identified states to report code 99024 for postoperative visits related to the original procedure during a global period from the list of 293 codes, CMS has indicated that those practices can also report 99024 for *all* services they perform that have a 10- or 90-day global period if they choose to do so. (Some practices indicated that they had a standardized process to capture postop visits for all codes with a global period, and it would be easier to report for all services than to try and isolate visits related to the CMS-identified services.)

If you are in an affected practice and use any of the above codes (or others included in the complete list linked above) for procedures performed on or after July 1, 2017, **you will need to report CPT code 99024 for each postop visit in addition to the actual procedure CPT code.** This code is for "*Postoperative follow-up visit, normally excluded in the surgical package, to indicate that an E&M service was performed during a postoperative period for a reason(s) related to the original procedure*."

- You should report CPT code 99024 through the usual process for filing claims, including practitioner, beneficiary, and date of service information.

- Only report 99024 once per day for postoperative visits that occur while the patient is in the hospital and follow-up visits in the office or other outpatient setting.

- Practitioners in the same group practice in the same specialty should be treated as though they were a single physician. Services provided by these practitioners should report CPT code 99024 for follow-up visits performed during the global period that are related to the original procedure.

    - *Example*: Dr. A goes on vacation and Dr. B covers for him, providing postoperative visits related to the original procedure during the global period. Dr. B should document the visit and report code 99024 for those visits during Dr. A's absence.

- Practitioners in the same group practice who are in *different* specialties should report the appropriate evaluation and management (E&M) code for the provided visits, not code 99024, even though they are occurring within the global period.

- For services within the global period that are *unrelated* to the original procedure and are provided by practitioners in the same group practice in the same specialty, report the appropriate E&M code and append modifier 24 to that E&M code.

- Teaching physician rules apply to services, including E&M, provided within the global period, so services provided by residents as part of the global should not be reported unless the physician personally documents that they performed the service or were physically present during the key or critical portions of the E&M when performed by the resident, and the teaching physician participates in the management of the patient.

Documentation: In addition to reporting the postop visit on claims, CMS also will require that postop visits be noted in the medical chart. While reporting the level of care is not part of the mandatory reporting starting on July 1, STS recommends that you document the postop visit as you would any other normal E&M visit (but without assignment of a traditional E&M code to that visit). Your postoperative documentation should capture and support the work you or your team are doing; however, the only CPT code you will submit for the postoperative visit(s) is 99024 for each visit.

It is important that practices capture all postoperative visits provided to patients and report them as part of the global. As indicated above, CMS is questioning the accuracy of valuation for 10- and 90-day global services and whether all the postop visits included in the valuation are being provided. If the data show that the visits are not occurring, CMS may reduce the value (RVUs) of the code accordingly. Capturing all visits performed by you, your partners, or covering physicians, mid-level providers, and residents is important. There are a variety of ways for practices to submit claims with code 99024:

- Claims can be submitted for each visit *as they occur*, submitted *weekly* with the number of visits provided during the week in the units box on the claims form, or submitted *at the end of the global period* with the total number of visits provided during the global period in the units box.

- You may need to add a charge ($0.01) to 99024 for claim processing purposes, and CMS is set up to accommodate this if necessary.

Nationwide CMS Survey: CMS also will conduct a survey of 5,000 physicians in mid-2017 to obtain additional data about the activities and resources used in providing services included in 10- and 90-day global periods. It is anticipated that this survey, in addition to collecting data on the performance of postoperative visits, will collect data on the level of service performed. This information will complement the mandatory claims data from nine states. If you receive a survey related to services provided as part of a 10- or 90-day global code, it is very important that you accurately and thoroughly provide the information requested, as it will be used to assess the accuracy of those code values.

Additional Resources

- STS has prepared a list of frequently asked questions and answers regarding the global surgical reporting requirements.
- Five STS surgeon members filmed a video discussing the impact of these new reporting requirements.

- The American College of Surgeons has additional resources on reporting services in the global period, including a webinar, fact sheet, and articles.
- CMS held a call entitled "Global Surgery: Required Data Reporting for Post-Operative Care" on April 25, 2017. Information from the call, including the global surgery data collection presentation, audio recording, and transcript, are available. You also can find more information on the CMS webpage on Global Surgery Data Collection.

If you have questions, contact Julie Painter at jpainter@physiciancoding.com.