New CMS Reporting Requirement: Post-Operative Visits Within the Global Period

Starting July 1, the Centers for Medicare & Medicaid Services (CMS) will require that certain practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island report the number of post-operative visits that they provide related to certain 10- and 90-day global services. The American College of Surgeons strongly urges all surgeons who are required to report to comply with this policy. If CMS is unable to collect accurate and complete data, then reimbursements for 10- and 90-day global services could be negatively affected.

Who must comply with this reporting requirement?

All practitioners who are in groups of 10 or more (“practitioner” includes both physicians and non-physician practitioners) who provide 10- or 90-day global services in the nine above-listed states are required to comply.

What must be reported?

Practitioners must report CPT code 99024, Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure, for every post-operative visit they provide within the global period for a select list of 10- or 90-day global codes. See www.facs.org/advocacy/regulatory/global-codes for the list of 293 applicable codes.

When does this reporting requirement begin?

Post-operative visit data must be reported starting July 1, 2017.

Why is CMS requiring reporting of post-operative data?

CMS is concerned about the accuracy of reimbursement for 10- and 90-day global codes. Specifically, the agency is questioning whether the number and level of post-operative visits currently included in the reimbursement for global codes are an accurate reflection of the care that is actually provided. The American College of Surgeons urges all surgeons who are required to report to comply. If CMS is unable to collect accurate and complete data, then reimbursements for 10- and 90-day global services could be negatively affected.

How should the codes be reported?

The codes should be reported through the usual process for filing claims, including practitioner, beneficiary, and data of service information. There is no need to link the 99024 code to the procedure itself or to add a modifier.

I am a surgeon who is required to report – where can I get more information?

If you have questions regarding this policy, contact the ACS at regulatory@facs.org. For more information, go to www.facs.org/advocacy/regulatory/global-codes or to www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Global-Surgery-Data-Collection-.html.