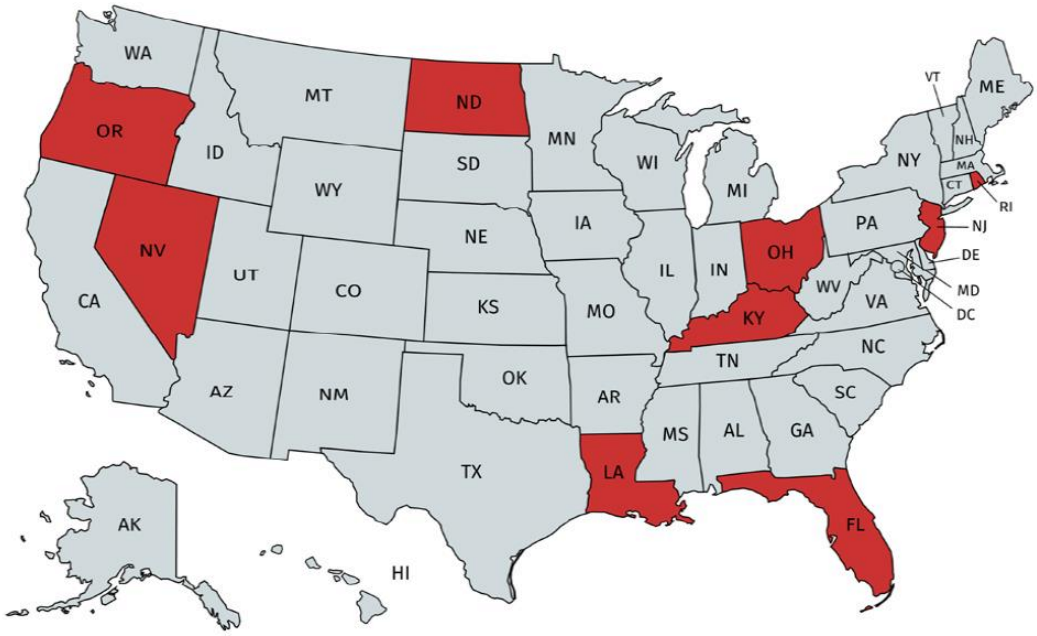
2017 Medicare Claims-Based Reporting Requirements for Postoperative Visits

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.



CMS will host a teleconference on "Global Surgery: Required Data Reporting for Post-Operative Care Call" for all interested providers on Tuesday, April 25, from 1:30 p.m. to 3:00 p.m. ET.

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 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
33405	Replacement aortic valve open
33426	Repair of mitral valve
33430	Replacement of mitral valve
33533	CABG arterial single*
33860	Ascending aortic graft
32480	Partial removal of lung
32663	Thoracoscopy w/lobectomy
43281	Laparoscopic paraesophageal hernia repair

*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.

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 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)." CMS has stated that it will provide additional guidance on how to properly report postop visits via CPT 99024, but that guidance has not yet been made available. Those seeking more information may consider participating in the CMS call referenced above.

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 evaluation and management 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.

Nationwide CMS Survey: CMS has stated that it will begin administering a nationwide survey in mid-2017 to obtain additional data on 10- and 90-day global codes that will complement the mandatory claims data from nine states. Therefore, if you receive a survey related to services provided as part of a 10- or 90-day global code, it is important that you accurately and thoroughly provide the information requested, as it will be used to assess the accuracy of those code values.

STS will provide additional guidance as it becomes available. Meanwhile, if you have questions, contact Julie Painter at jpainter@physiciancoding.com.