

May 2017

New Requirement – Reporting Services in Global Period

The Centers for Medicare & Medicaid Services (CMS) CY 2017 Physician Fee Schedule Final Rule includes the final policy and data collection requirements for validating the value of services with 10 or 90 day global periods by reviewing related services provided within the global period. CMS will implement a three-pronged approach to include claims-based reporting, a survey of selected practitioners and collecting data from some Accountable Care Organizations (ACOs). This Timely Topic will focus on the claims-based reporting approach. It will present the requirements outlined in the Final Rule specific to the claims-based approach, cover some open questions that still need to be addressed to ensure accurate data collection and provide information on additional resources to assist you in your preparation to meet this new requirement.

Background

In the 2015 Physician Fee Schedule Final Rule CMS determined that all 10-day and 90-day global periods would be converted to 0-day global periods by 2017 and 2018 respectively. Per CMS, the purpose of these changes was “to improve accuracy of valuation and payment for the various components of global packages, including pre- and post-operative visits and the procedure itself...” The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) prohibited this policy from going into place and instead mandated that additional data be collected and then be applied to insure the accuracy of the fee schedule. MACRA requires that data gathering process to begin in 2017 and be applied to the fee schedule in 2019.

The data gathering requirements include collecting information about the number and level of medical visits during the global period, as well as any other items and services related to the procedure within the global period. MACRA also instructs that the collected data be audited for accuracy and authorizes a penalty of up to 5% of the physician fee schedule allowed charge if a physician or other provider does not report the required information. While the penalty is not being implemented at this time, it is important that all applicable services be reported so there is greater accuracy in the data collected. This data may have an effect on future payments for the impacted services.

The Final Rule for Claims Based Reporting

The Final Rule significantly differs from what was originally proposed. You can review our [Timely Topic](#) from September 2016 for more information regarding the proposed rule.

Who is required to report?

Only a representative sampling of providers will initially be required to report on related services in the global period of a procedure. Reporting will be required for providers located in the following nine states: Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island.

Within these states only those practitioners (both physicians and non-physician practitioners) who meet all of the following criteria are required to report:

1. Practice in one of the nine identified states; and
2. Practice in a group of ten or more practitioners; and
3. Are part of a practice that provides global services under one of the selected procedure codes.

For the purpose of this Final Rule, a practice is defined as “a group of practitioners whose business financial operations, clinical facilities, records, or personnel are shared by two or more practitioners.” Also for the purposes of this data collection rule, a practice is not defined by specialty, NPI or TIN and the practitioners do not need to share the same physical address. All physicians and non-physician practitioners are included in determining the size of the practice, regardless of whether through an employment model, partnership model or an independent contractor model. CMS states that eligibility is based on the typical number of practitioners that worked in your practice the first six months of 2017. Typically a locum tenens who is only engaged for a limited period would not be included in your practitioner count.

If you do not meet all three of these criteria, you are not required to report at this time. However, you may report your post-operative services voluntarily.

What procedures trigger the reporting requirement?

Initially only post-operative services during the global period of 293 CPT codes must be reported. CMS analyzed claims data from 2014 to determine the most commonly reported services with 10 or 90 day global periods. The 293 services were identified as those:

- reported by more than 100 practitioners, and
- reported more than 10,000 times or account for more than \$10 million in allowed charges.

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The following codes often performed by pain medicine specialists are included in the list of required procedure codes:

62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64640	Destruction by neurolytic agent; other peripheral nerve or branch

Be sure to review the full list of 293 codes found [here](#) to ensure you do not perform any other services that will require reporting in 2017. The list of codes will be updated each year.

What needs to be reported and how?

If your practice is in one of the nine selected state and you or any other practitioners perform any of the services in the list of identified services, you must report all post-operative services in the global period that are related to a qualifying procedure performed on/after July 1, 2017. Post-operative services include any follow up services rendered for reasons related to the original procedure. These services can occur in any location including office, inpatient, outpatient clinic, nursing facilities and even eligible originating sites for telehealth services.

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 - should be used to report all post-operative services in the global period. This code is always bundled into the original procedure and not paid separately. There has been no change in what constitutes expected care included in the global period or in the payment for the procedure; no charge or payment is to be associated with code 99024. If your billing software will not produce a claim with a \$0.00 charge, CMS suggests you assign a \$0.01 charge. CMS encourages you to submit claims for post-operative related services prior to July 1 to test your software and clearinghouse.

Multiple visits may occur during the global period. If so, multiple units of 99024 can be reported on the same claim line as long as the corresponding date range is included.

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Consistent with other E/M reporting rules, multiple units of 99024 should not be reported for the same date of service.

Other instructions from CMS include:

- No time units or modifiers are needed. Teaching physicians should follow CMS policy by using modifier GC (*This service has been performed in part by a resident under the direction of a teaching physician*) or GE (*This service has been performed by a resident without the presence of a teaching physician under the primary care exception*) when appropriate.
- According to CMS, you do not need to link the claim for code 99024 to the original procedure. Your documentation should support that a follow up service was provided in the global period.
- Do not report the 99024 if other unrelated or separately identifiable care is provided at the same visit for post-operative services. In that circumstance, report the relevant codes for the other services provided.
- Reporting 99024 is still required if the post-operative care is transferred to another provider in the same practice.
- Reporting is required only for services provided to Medicare Part B beneficiaries with traditional fee-for-service policies.

Implementation Concerns

The ASA joined 22 other specialty societies in a letter to HHS Secretary Tom Price, M.D. and CMS Administrator Seema Verma. Read the letter [here](#). The letter expresses concerns regarding several key components of the data collection requirements. Because the goal of data collection is to create a more accurate valuation of care, it is essential that the data collected is accurate and that a well-vetted methodology be used in its analysis. The joint letter requests a postponement of the data collection requirement. If the July 1, 2017 start date is not delayed then the letter recommends that CMS not use any flawed data to revalue global codes in 2019. Since no such delay is guaranteed, those who will be required to report should prepare now to be able to do so starting with service provided on/after July 1, 2017

Additional Resources:

[CY 2017 Physician Fee Schedule Final Rule](#)

[CMS Global Surgery Data Collection](#)

Medicare Learning Network Slides: [Global surgery: Required Data Reporting for Post-Operative Care Call](#)