Frequently Asked Questions (June 2017)

Who Should Report

Practitioners are required to report post-operative evaluation and management (E/M) visits using Current Procedural Terminology (CPT) code 99024 if they:

- **Practice in one of the following nine states: Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, or Rhode Island; and**
- **Practice in a group of ten or more practitioners; and**
- **Provides global services under one of the required procedure codes.**
  The term "practitioner" is used to refer to both physicians and nonphysician practitioners (NPPs) who are permitted to bill Medicare under the PFS for services furnished to Medicare beneficiaries (see 81 FR 80172).

1. **Is reporting required for all practitioners in our practice or just those who furnish procedures?**

   Answer: Reporting is required for all eligible practitioners in a practice furnishing post-operative visits included in the global period regardless of whether or not the practitioner furnished the procedure itself. This new reporting requirement does not change what care is included under the global payment. As a result, any service that was separately reportable prior to the reporting period should continue to be reported separately using the appropriate CPT or Healthcare Common Procedure Coding System (HCPCS) code.

2. **What if I practice in two practices, but only one meets the size threshold?**

   Answer: Practitioners are required to report if they have relationships with at least one practice with 10 or more practitioners. Practitioners in this situation must report all eligible post-operative visits, no matter which practice is associated with the procedure.

3. **Does the taxonomy, tax ID structure, practice location, billing arrangements, or part-time/short-term status of the practitioners relate to the determination of whether a practice has 10 or more practitioners? Does my alternative employment model affect the practice size threshold?**

   Answer: Those who practice with fewer than 10 billing practitioners are exempt from the reporting requirements. For this purpose, practitioners are exempt from the required reporting if they share business or financial operations, clinical facilities, records, or personnel with fewer than 10 practitioners, regardless of whether they are furnishing services under an employment, partnership, or independent contractor model under which they practice as a group and share a facility and other resources but continue to bill Medicare independently instead of reassigning benefits.

4. **If a surgical procedure is furnished in a state that is not included in the sample, but the post-operative visits are furnished in a state that is included in the sample, or vice versa, is reporting required?**

   Answer: Reporting is required by eligible practitioners in the nine states who furnish services that are part of the global periods, regardless of whether or not all of the post-operative visits are furnished in one of the nine states.

5. **If a practice has 10 or more practitioners, but is located in a state other than the 9 states included in the sample, is the practice required to report CPT code 99024 for post-operative visits?**

   Answer: No, only practices that have 10 or more practitioners AND are located in the following 9 states are required to report: Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, or Rhode Island.

Timeframe for Reporting

6. **Do I need to report visits associated with services provided before July 1, 2017?**

   Answer: No, reporting is only required for post-operative visits during the global period for procedures with dates of service on or after July 1, 2017.

Which Visits Should be Reported

7. **Does the post-operative reporting requirement apply to pre-operative visits that are part of the global period for procedures with 90-day global periods?**

   Answer: No, the reporting requirement applies to post-operative visits only.

8. **Is reporting of CPT code 99024 required for inpatient hospital visits, or only for office visits?**

   Answer: Reporting of CPT code 99024 is required for all post-operative visits furnished during the global period, regardless of the setting in which the post-operative care is furnished.

9. **What if post-operative care is transferred to another practitioner and billed with modifier 55?**

   Answer: In situations in which the practitioner who performs the procedural part of the service transfers post-operative care to another practitioner (e.g., ophthalmologist to optometrist) using modifier 55, the practitioner who assumes the post-operative care portion of the service should report CPT code 99024 for post-operative visits if they meet the reporting requirements (i.e., they practice in one of the states selected and their practice includes 10 or more practitioners).

10. What if I furnish other services to the same patient on the same day?

Answer: Post-operative visits covered by the global period must be reported if they would otherwise be separately reportable if not for the global period. If furnishing multiple post-operative visits to the same patient on the same day, only report CPT code 99024 once (the same as E/M rules). Post-operative visits should be reported with CPT code 99024 when the visit is furnished on the same day as an unrelated E/M service (billed with modifier 24). This new reporting requirement does not change what care is included under the global payment and any services not covered by the global period are subject to normal billing rules.

11. Is reporting also required for Medicare Advantage and Veterans Administration patients?

Answer: Reporting is only required for traditional fee-for-service Medicare patients for whom Medicare was the primary payer for the global procedure.

12. Are post-operative visits furnished by Rural Health Clinics (RHC) or Federally Qualified Health Centers (FQHC) subject to the reporting requirement?

Answer: Under current Medicare policy, if a RHC or FQHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC or FQHC must determine if these services have been included in the surgical global billing. RHCs and FQHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package. When RHCs or FQHCs bill for the visit, 99024 should not be separately reported.

If the service furnished by the RHC or FQHC was considered included in the global payment for the surgery, and the practitioner furnishing the visit is required to report post-operative global visits, the practitioner should report these visits as 99024 with the applicable place of service coding.

13. If a service provided by hospitalists or intensivists to a patient within a global period is reported using an E/M code, would that now be reported using 99024 instead?

Answer: This new reporting requirement does not change what care is included under the global payment. CPT code 99024 should only be reported for post-operative visits that are not otherwise reported because it is included in the global period. If the visit is not currently reported because it is part of the global period, then CPT code 99024 would be reported. This new reporting requirement does not change what care is included under the global payment.

14. How should post-operative visits furnished via telehealth be reported?

Answer: CPT code 99024 should only be reported for post-operative visits that would not reported otherwise because it is delivered during the global period even though it meets all the other the requirements for E/M visits. Therefore, CPT code 99024 should only be reported with the place of service (POS) code 02 for a post-operative visit that meets all

of the telehealth billing rules, including the geographic and setting requirements for the location of the patient. For more information, please see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf.

Questions Regarding Claims Processing

15. Are CMS contractors prepared to accept CPT code 99024? Can a small charge be put on the claim?

Answer: Medicare Administrative Contractors can process claims with CPT code 99024. Practitioners can put a charge on the claim.

Other Questions

16. Is it necessary to connect the claim on which CPT code 99024 is reported to the claim on which the initial surgical procedure is reported?

Answer: No. CMS recognizes that there are several challenging aspects of analyzing the data collected under this requirement and intends to engage with several stakeholder groups so that any potential use of the data in valuation will be as accurate as possible.

17. What process will be used to audit the data collected regarding post-operative care?

Answer: Section 1848(c)(8)(B)(iii) of the Social Security Act specifies that the Inspector General of the Department of Health and Human Services shall audit a sample of the collected information to verify its accuracy.

18. Where can I find more information about the claims-based reporting requirements?

Answer: Please direct all questions for CMS to the following resource email box: MACRA_Global_Surgery@cms.hhs.gov. You can also find online resources on the CMS webpage at the following link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Global-Surgery-Data-Collection-.html.