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Centers for Medicare & Medicaid Services
Global Surgery:
Required Data Reporting for Post-Operative Care Call
MLN Connects National Provider Call
Moderator: Leah Nguyen
April 25, 2017
1:30 pm ET

Contents

Operator: At this time, I'd like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects Call on Global Surgery – Required Data Reporting for Post-Operative Care. MLN Connects Calls are part of the Medicare Learning Network®.

The calendar year 2017 Medicare Physician Fee Schedule Final Rule adopted a data reporting requirement for practitioners furnishing specified global procedures in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island.

CMS will use reported data, along with other data, to establish payment rates under the Physician Fee Schedule. During this call, learn about the new requirements that go into effect July 1st and resources you can use for reporting. A question-and-answer session follows the presentation. Before we get started, I have a couple of announcements.

You received a link to the presentation for today's call in previous registration emails. You can download the presentation from the following URL – go.cms-gov/npc. Again, that URL is go.cms.gov/npc. Second, this call is being recorded and transcribed.

And, finally, registrants were given the opportunity to submit questions during registration. We will address many of your questions today and will also use them to develop future resources. At this time, I would like to introduce Marge Watchorn, Deputy Division Director of the Division of Practitioner Services at CMS.

Presentation

Marge Watchorn: Thank you, Leah. Good afternoon, everyone. My name is Marge Watchorn. I wanted to begin on slide 2 of the presentation and share with you some disclaimers.

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently, so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

And, then, the CPT disclaimer from the American Medical Association Notice – CPT codes, descriptions, and other data only are copyright 2017 by the American Medical Association. All rights reserved. So, slide 13.

Here's our agenda for today. We hope to share with you how global service reporting is changing, provide information on what procedures require reporting, who is required to report, when these new requirements take effect. We'll share with you some frequently answered questions that we've received. And, finally, we'll provide you with an opportunity to ask the subject matter experts here at CMS some questions about these requirements. Slide 4.

How Global Service Reporting Is Changing

How is global service reporting changing? Selected practitioners are required to report on post-operative visits furnished during a global period. This will be achieved by using current procedural terminology CPT code 99024. And this is for post-operative visits following 293 specified procedures. And this applies for procedures that are furnished on or after July 1, 2017.

Slide 5. What is a post-operative visit? This is considered followup services that are performed during the post-operative period for reasons that are related to the original procedure. They are visits that are covered by the global period. Those are the visits that we are requiring you to report.

The visits can occur in all sites of care including, but not limited to, ICUs, an outpatient clinic, or skilled nursing facility. We also want to note that relevant telehealth visits should also be reported if the patient is located at an eligible originating site.

Slide 5. Which services should be reported? The requirement is that you report post-operative visits following selected procedures. And we have, again, a list of 293 codes that will be reported for calendar year 2017. These procedures were selected based on 2014 data. We selected procedures that were furnished in that year by more than 100 practitioners and procedures that were performed 10,000 times or that have allowed Medicare charges exceeding $10 million.

We accounted for changes in CPT coding between 2014 and calendar year 2017. And the procedure codes that are subject to reporting will be updated yearly and published prior to the beginning of the reporting year. We want to note that reporting is not required for pre-operative visits within the global period or for services that are not related to a patient's visit.

Who Reports and How?

Slide 7. Who is required to report? This would be billing practitioners, defined as physicians and non-physician practitioners, are required to report post-operative visits if they practice in one of the nine states that were randomly selected by CMS, if they practice in a group of 10 or more practitioners, and if they are a part of a practice that provides global services under one of the required procedure codes. Practitioners who are not required to report are still encouraged to report post-operative visits. And we note that if you are voluntarily reporting, we encourage you to report all visits for all of the selected procedures.

Slide 8. Who is required to report? And this slide provides a map, and it's based on practice location. We note that in order to reduce the overall burden on providers nationwide, we're only requiring reporting for practitioners whose practice is located in the following states.

And I will read them again. I know Leah shared them at the beginning of the call. Those states are Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island. The states were randomly selected to be representative with

respect to size based on the number of Medicare beneficiaries in the state as well as geography. We used the Census Division.

Slide 9. Which practitioners are required to report? This is based on the practice size. So, practitioners who practice in at least one group of 10 or more practitioners are required to report all post-operative services that are provided even if you practice in more than one group. Practitioners are exempt from reporting if they practice exclusively in groups with fewer than 10 practitioners.

And then, more information on the practice size. Practices are defined as a group whose business or financial operations, clinical facilities, records, or personnel are shared by two or more practitioners and not necessarily practitioners who practice at the same physical address. Again, practitioners are defined as physicians and non-physician practitioners, including non-physician practitioners who work under physician supervision.

Slide 11. How do I report post-operative visits? Post-operative visits will be reported through the usual process for filing claims. You'll need to include information on the practitioner, the beneficiary, the date of service. You don't need to link reporting of CPT code 99024 to the claims for the procedure that was performed. There are no time units or modifiers required for the claim.

Practitioners can submit multiple 99024s on the same line as long as the claim includes the applicable range of service dates. And, again, you follow the usual Medicare billing requirements to demonstrate that the visits were provided and that the code was correctly used such as a note in the patient's chart. Teaching physicians will follow the usual CMS policies for reporting CPT code 99024 using either the GC or the GE modifier, as appropriate.

Effective Date for Reporting Requirements

Slide 12. When do the reporting requirements take effect? Practitioners are required to report post-operative visits for selected procedures that are furnished on or after July 1, 2017.

It's optional to report anytime beginning January 1, 2017. So you don't have to wait to report on the required date. You can report early. We do recommend that you

implement reporting as soon as possible so that your software can be updated, to test the systems, and to train staff as necessary.

So slide 13. We do have quite a bit of information already on the website. And we have an email address dedicated to this effort. That email address is macra – M-A-C-R-A – underscore global – G-L-O-B-A-L – underscore surgery@cms.hhs.gov with any questions that you have.

And, then, we have a series of websites. I won't read them all out. But I'll just say that we have the full text as well as supplemental information on the calendar year 2017 Physician Fee Schedule final rule, which is the rule that includes these requirements that we're speaking about today.

There's the list of the 293 procedure codes that require post-operative visit reporting. That's also on our website. We have an informative fact sheet on the global surgery requirements. And then, in general, we have a separate landing page dedicated to information about global surgery data collection. And at this time, I'll turn it back over to Leah.

Keypad Polling

Leah Nguyen: Thank you, Marge. At this time, we will pause for a few minutes to complete keypad polling. Holley, we are ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine. Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine. Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Please continue to hold while we complete the polling.

Again, please hold while we complete the polling. And thank you for your participation. I will now turn the call back over to Leah Nguyen.

Leah Nguyen: Thank you, Holley. I will now turn the call back over to Marge to discuss some frequently-asked questions about global surgery.

Presentation (Continued)

Marge Watchorn: Thank you, Leah. Before we proceed with the frequently-answered – asked questions that are included in the slide deck, I wanted to just note some, I guess, broad categories of questions that we've already received.

Frequently Asked Questions

In general, there's been a lot of questions about when do practitioners report the 99024. And our position is that you report the 99024 only if the only reason you would not have otherwise reported it is if the visit occurred during a global period. In other words, if – you wouldn't report a 99024 if you visited – if you had a patient where you visited, say, two or more times in a day. In that circumstance, you would only report the 99024 once. The same is true for reporting under the global surgery requirements. You would only report 99024 once per day per patient.

Also, if, say, the visit was performed via telehealth but, for one or more reasons, if one of the telehealth requirements were not met, then you would not report 99024 under this requirement. If the visit was provided incident-to but, for some reason, all of the incident-to requirements were not met, then you would not report the 99024 for these requirements. So, I just wanted to address that kind of broadly.

Also, there's been questions that we received regarding what constitutes a practice. The intent there is not for CMS to necessarily get involved in all of the business requirements and, you know, the different kinds of corporate and business relationships between practitioners.

But, really, the intent there was to target the practices that have 10 or more practitioners involved in their operations. So, the intent was to hit the larger practices. And if – you know, if there's practitioners who only practice in the smaller practices, the

intent was that you would not be required to report if you practice in one of the nine affected states.

We've also received a number of questions regarding how we intend to use the data that we collect for evaluation of services and procedures under the Physician Fee Schedule. Suffice it to say that any use of the data that we collect for this effort, any use that would apply to the Physician Fee Schedule would need to be taken through notice and comment rulemaking.

So, we don't, in any way, anticipate anything for calendar year 2018. Generally speaking, when we do use data for rulemaking, generally we use a full year's of data. And for this requirement, we would only expect to have a partial year for the data that we collect during calendar year 2017. So, you know, the intent is that this would be used for future rulemaking. And we would certainly provide proper notice and – notice to the public and affected stakeholders through the rulemaking process.

Okay. So now I'm going to flip back to the slides. On slide 15. What if the post-operative care is transferred to another practitioner? Reporting is required when a post-operative visit is furnished by another practitioner in the same practice or Tax Identification Number or TIN. This new reporting requirement does not change what care is included under the global payment.

So if another practitioner in the TIN provides care that's unrelated to the procedure, that practitioner should continue to bill using the relevant evaluation and management or E&M code or other health care procedure coding system or HCPCS code. For some procedures, it is common for the practitioner who performs the procedure to transfer post-operative care to another practitioner such as an ophthalmologist who transfer care to an optometrist using modifier 55.

That practitioner who assumes post-operative care should submit code 99024 claims for post-operative visits if they meet other sampling requirements; in other words, if they practice in one of the nine states that are selected and if their practice includes 10 or more practitioners.

Slide 16. Do I need to report visits associated with services provided before July 1? And the answer is no, reporting is required for post-operative visits during the global period for procedures with dates of service on or after July 1, 2017.

Slide 17. What if I furnish other services to the same patient on the same day? The answer is, all post-operative visits covered by the global period must be reported. And if you furnish multiple post-operative visits to the same patient on the same day, again, you would only report 99024 once. And we note that that's the same as the reporting rules for E&M codes currently that are paid. Any service that's not covered by the global period would be subject to the normal billing rules.

Slide 18. What if I practice in two practices but only one meets the size threshold? You would still be required to report. Practitioners are eligible if they have relationships with at least one group with 10 or more practitioners. Practitioners in this situation must report all eligible post-operative visits no matter which practice is associated with the particular procedure.

Slide 19. Does my alternative employment model affect the practice size threshold? Practitioner count should include all billing physicians and non-physician 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 facility and other resources but continue to bill Medicare independently instead of reassigning the benefit.

Slide 20. How do we account for part-time or short-term practitioners and staff fluctuation? When practitioners provide services in multiple settings, the count may be adjusted to reflect the estimated proportion of time spent in the group practice and other settings. Generally, practitioners in short-term locum tenens arrangements would not be included in the count of practitioners. Practices should determine their eligibility based on the typical number of practitioners that work in the practice during the first 6 months of 2017.

Is reporting also required for Medicare Advantage and VA patients? Reporting is only required for traditional fee-for-service Medicare patient. Reporting is required when Medicare is the primary payer for the global procedure.

Slide 22. Are CMS contractors prepared to accept 99024? Can a small charge be put on the claim? The answer is we are currently working with our contractors to ensure appropriate processing of these claims. We're working with contractors to ensure that providers will be able to put a 1-cent charge on the claim if the provider's software requires that there be a charge on the claim.

So, in summary, select practitioners are required to report post-operative visits furnished during global periods starting on or after July 1, 2017. The reporting requirements apply to practitioners in practices of 10 or more practitioners and in nine randomly-selected states. Reporting required for post-operative visits furnished during global periods following 293 specific procedure codes, which, again, are on our website. CPT code 99024 is reported using the usual claims filing process. Reporting is optional for all other practitioners and prior to July 1, 2017. And, now, we'll begin our Q&A. I'll turn it back over to Leah.

Question-and-Answer Session

Leah Nguyen: Thank you, Marge.

Now our subject matter experts will take your questions. As a reminder, this call is being recorded and transcribed. Once your line is open, state your name and organization, then ask your question. If you have a followup question or more than one question, press star, one to get back into the queue, and we will address additional questions as time permits. All right, Holley, we are ready for our first caller.

Operator: To ask a question press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster.

Our first question will come from the line of Jennifer Ellis.

Jennifer Ellis: Yes. I was wondering, is this being done because the global periods are being considered for – that they're considering to be retracted and that providers will

be able to bill for post-operative visits and the global package won't be in place in the future?

Ryan Howe: Hello. Thank you for the question. It is nice to be able to join. My – excuse me. My name is Ryan Howe. I'm the Director of the Division of Practitioner Services. And just to provider a little bit more background in hopes of answering your question thoroughly, CMS proposed several years ago to transition away from the 10- and 90-day global periods.

And by law, that proposal was not implemented and, instead, this data collection effort took its place. There were several rationales for wanting to move to transform the global periods. And one of the primary ones was related to accurate evaluation of the packages.

And, so, the data collection here by law is aimed toward improving the accuracy of the payment rates for the global surgery packages. And, so, that's a relatively long answer to a short question. But the answer is that, at present, there is no plan to change the structure of the global surgery packages. Rather, the data collection is seeking to improve the accuracy of the valuations.

Jennifer Ellis: Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Sandy Perez.

Sandy Perez: Yes. Hi. Good afternoon and thank you for taking my call. Maybe you discussed it, but I'd like to – a clarification. We are a multi-specialty group with a number of surgical specialists. All the practices and each of the specialties have their own group NPI. But we're all under one single tax ID number.

Do we have to look at the requirements of greater than 10 practitioners by individual group NPIs, or would we have to report for all our NPI practitioners because we're all under the same tax ID? Thank you.

Ryan Howe: So, as Marge mentioned, the cutoff between 10 or more practitioners versus nine or fewer is intended from a policy perspective to exempt practices where –

whose operation is fewer than 10 practitioners from having to report. It sounds like in your scenario, there are sort of some joint resources. And so, from a policy perspective, the intention would be for you to report those post-operative visits using the 99024. And that's consistent technically with the tax ID policies.

Sandy Perez: Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Tamara Bradford.

Tamara Bradford: Hello. Good afternoon. We are a large hospitalists group, and we do provide services in various settings: inpatient, outpatient, and SNF. Would the guidelines for 99024 apply the same to us when we have a separate tax ID?

Leah Nguyen: Hold on one moment.

Ryan Howe: So, if you don't mind, if I can just ask a followup question. Are you saying that you have different tax IDs, but you are operating with more than 10 billing practitioners typically?

Tamara Bradford: Correct.

Ryan Howe: Then the policy would apply that you would need to report.

Tamara Bradford: Okay. Thank you.

Leah Nguyen Thank you.

Ryan Howe: Thank you much.

Operator: Our next question will come from the line of Katie Smith. Katie, your line is open. That question has been withdrawn.

Our next question will come from the line of Roberta LaBarata.

Roberta LaBarbera: LaBarbera. I would like to know if – is there going to be any grace period allowed for any software issues that are not going to be able to be implemented by this July 1 date.

Ryan Howe: So, at present, there's no formal grace period. However, at the moment, there's no imposition of penalties as well as – what we're interested in is taking a look at the data and seeing where there are problems. So, we definitely would be interested in knowing.

And if you can submit information about potential problems with particular software or vendors, I think it would be interesting for us to be aware of that so we can take that into account – the kinds of problems that are happening. And you can submit that information to the email address for questions, and that will be very helpful to us.

Again, there's no formal grace period. I think we understand that anytime there's implementing a change where there's additional required reporting, particularly for codes that aren't separately payable, sometimes there are issues with software, and I think that, generally, we are aware of that.

And, so, while there's no formal grace period in terms of both the use of the information and the consequences, I think, as a practical matter, the agency's aware that there can be a bump sometimes getting these things fully off and running.

Roberta LaBarbera: Thank you.

Marge Watchorn: And this is Marge. I just wanted to note that the email address appears on slide 13.

Roberta LaBarbera: Thank you.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Brian Vineman.

Brian Vineman: Yes. Hello. My question is, does Medicare have a plan to return a remit on claims that have this 99024 code billed on? And if so, what will the remittance code

be for – the code? Is it going to be a typical CO 45 contractual or will it be a rejection code?

Ryan Howe: Leslie, are you on and are you able to help us with that?

All right. I apologize. Our – the folks who can address some of those more specific detailed questions are not on the line at the moment. But if you can submit that question, we'll make sure that we answer that question in documentation in terms of the frequently asked question. Looking around the room – and I don't think we have the billing expertise in the room.

Leah Nguyen: Thank you.

Operator: And our next question is going to come from the line of Jen Gladson.

Jen Gladson: Hi. How are you? I am – I'm thinking, is this data going to be utilized to revalue the surgery codes reimbursements?

Ryan Howe: So, that's a great question. Thank you for asking it. Yes, the intent of the data is to help inform the appropriate and accurate valuation of the services. The process under which the current services are valued under the PFS relies heavily on the claims data at present. That's for the full range of the PFS services. And, so, though the – it's not exclusively based on the claims data.

And so, I think any potential revaluation, as Marge said, would be made through notice and comment rulemaking, meaning that the public both from the medical specialty societies as well as any interested member of the public would have the opportunity to comment on the validity of those values. So that would – that rulemaking would take place before we would use this data. And like much of the other data that is used in the process of setting the rates, it would be one additional component of the information rather than a strict sort of copy and paste, if you will, taking the data and applying it. So, again, the answer's yes. But it would be part of a broader process of setting the rates under the PFS and you'd certainly have lots of opportunity for comments.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Susan Eosso.

Susan Eosso: Good afternoon. Currently, we certainly code 99024 for all our post-op followup visits in the clinic or the physician office setting. Do we need to capture inpatient followup for surgery also?

Ryan Howe: Yes. The intention of the policy is to capture all of the post-operative visits that would ordinarily be reported were they not contained within the global period.

Susan Eosso: Okay.

Ryan Howe: So, if the services furnished by the surgeon in a post-operative followup visit would ordinarily be captured through an inpatient – say, an inpatient evaluation management code, then the 99024 would be required to be reported.

Susan Eosso: Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Amanda Attaway.

Amanda Attaway: Hi. Thank you for your time. For larger integrated health systems working under the same tax ID number, same group NPI, with multiple specialties including emergency, urgent care, and primary care under that same tax ID and group NPI, we're assuming that that also means that if this patient drifts into the ER, urgent care setting, maybe their primary care setting, and it's unclear whether or not this particular visit is related to a surgical complication that, too, the expectation is that the physician will bill this as a 99024 if it's within that global – if it's determined that it's related to that surgery?

Ryan Howe: So, again, another great question. Thank you for asking it. So, the intent of this policy is not to change any of the current payment policies regarding services that may or may not be related to post-operative services.

So, in other words, in the scenario now where a patient who may have had a recent procedure done and would ordinarily be getting surgical followup care, if that patient is in a primary care setting for a related or unrelated reason and that – and under the

current rules they would bill separately an evaluation and management code, say a level-three office visit, then they should continue to do what they would have ordinarily done.

In the case where they would have reported the 99213, say, but they don't because they consider it to be part of the global package, then, yes, in that scenario, then they would report the 99024. So, again, the goal here is to capture the visits that are happening that aren't otherwise reported because they're considered to be part of the global package.

Amanda Attaway: Thank you. I appreciate it.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Edward Vates.

Edward Vates: Hi. I'm calling just – and this may not be something you can answer now. But assuming that for some codes the data shows that the amount of post-operative work provided in the code is not being done – let's say 20 percent of reportings for a particular code don't show the amount of post-operative work being done – what is the threshold at which CMS is going to say a code needs to be revalued?

Is it going to be when 25 percent of billings don't show the appropriate post-op work? Is it going to be 50 percent? Is it going to be 10 percent? Do you have any idea where CMS is going to draw the line there?

Ryan Howe: So, that's a great question. I think it would be hard to offer a speculation about what the appropriate threshold would be without looking at the information.

Again, I think it's important to stress that we're interested in taking a look at the data to have more information about what services are being furnished within the global packages and not currently counted under, sort of, under the claims process. I think, in terms of what the threshold might be for identifying potential problems, I think we'd have to look at that in the context of the rest of the data as well as the ongoing valuation process under the fee schedule more generally.

We certainly recognize that there are questions. There are questions about what to do once we have this data and how it might be used.

And I think we understand very, very clearly that that can cause a lot of anxiety for the folks who obviously are being paid for their services using the valuation for these services currently. But, I think, what we're interested in is gaining the information so that we understand a lot of the services more accurately – the services that are being furnished.

And, then, once we have that information, we'll continue to consider how best to use it to improve the accuracy of the values. But, at this point, there's no current plan either in established policy or, frankly – and, frankly, I don't think it would be wise for us to, before we see the data, have a precise plan about how it might be implemented.

Edward Vates: Great. Thank you.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Candice Fenildo.

Candice Fenildo: Hi. So, I appreciate the fact that if a physician other than the surgeon provides post-op care and they both practice in the same TIN, that the second physician should report the 99024. In a practice with two or more surgeons where this might happen, has there been given any thought as to how CMS will be able to relate which surgical procedure the post-op visit actually relates to?

And, also, for patients who go back to the OR for a related or unrelated surgical procedure where the global period, depending on the modifier, may actually not restart, has there been – does CMS know yet how it's going to correlate the post-op visits to which surgical procedure?

Andrew Mulcahy: Hello. This is Andrew Mulcahy from the RAND Corporation. I'm the Project Director for the study that will do some analysis based on the data collected through this required reporting. And we're aware of many of the challenges in linking up visits reported with 99024 to specific procedures.

We're currently developing with CMS an analytic approach to tackle some of those challenges. And that's something that will be under development while data collection begins. But, I think, there are…

Candice Fenildo: That's great.

Andrew Mulcahy: We recognize an important set of concerns in linking up visits to their corresponding procedures.

Candice Fenildo: Sure, thank you, Andrew.

Ryan Howe: If I could just add one more thing. And thank you, again, for the question. I think one of the challenges with colleting the information is balancing the potential burden of all of the different scenarios...

Candice Fenildo: Yes.

Ryan Howe: ...with the data analysis on the back end. And, I think, where we came out from a policymaking perspective is to finalize and implement a policy that reduced the burden on the front end with the understanding that there's a lot of data analysis work that will be challenging, but we believe is preferable to additional burden on the front end.

Candice Fenildo: Thank you. That's so nice to hear. Is that one of the reasons why we're also not speaking about the other two components as to how this was originally proposed, such as the surveys and the observations?

Ryan Howe: The surveys and the observation are ongoing projects and beyond the scope of the call directly. But the goal with both of those are – again, is to gain as much information as necessary to improve the accuracy without inducing an inordinate amount of burden.

Candice Fenildo: Right. Thank you so much, Ryan.

Ryan Howe: Sure.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Catherine Cher.

Catherine Cher: Yes. Thank you. We are practicing in a border state. We do do surgeries in Ohio. But, most of our followup care is provided in our office setting, which is West Virginia. So most of our 99024s will be billed from the West Virginia location. Is that going to be an issue?

Ryan Howe: That's a great question. I think that's a very important data analytic question. I think here' a scenario where it will certainly help us where voluntary reporting happens. But we understand that there are certain scenarios where, depending upon which direction things work, the requirements may be difficult.

And, so, that'll be on the list for RAND and us as we think about how to interpret the data. We do – we will have information. One of the benefits of the – of using the claims system is that we do have geographic information on the claims that are submitted. And, so, we may have to make that a variable for looking at the value of the data in the analysis.

Catherine Cher: Thank you.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Angela Stewart.

Angela Stewart: Hi. Yes. Thank you. Not to state the obvious, but it sounds like you're totally omitting sole practitioners.

Ryan Howe: Yes. That is correct.

Angela Stewart: You have no idea how happy that answer just made me and my boss. Thank you so much.

Leah Nguyen: You're welcome. Thank you.

Operator: Our next question will come from the line of Eric Whitacre.

Eric Whitacre: Good afternoon. My question relates to the validation of the data received with this project. As a practicing surgeon and as has already been mentioned

earlier in the call, there are any number of obstacles to changes – rapid changes in clinical care, and billing, obviously, is a part of that. This is compounded by problems in the EMR, as well as in clearinghouses.

And so I see or have a concern that underreporting may be an issue. And since I know your goal is accuracy in assessment of the post-operative work, I was wondering if you have a validation strategy in place to verify the data you receive, whether it's random audits of the data or some other technique.

Andrew Mulcahy: This is Andrew Mulcahy from RAND again. Just two parts to your answer. And Ryan may want to add to this, too. I think that's one reason why there's an interest in tracking data reported over time and over the initial months after reporting is required. That's part of our analysis plan will be to look for changes over time. I think I'll just pause there and see if...

Ryan Howe: I think that that's part of the reason why it's helpful to hear what the practical concerns are in terms of particular vendors or particular software systems or in particular systems less from an enforcement perspective and more from the data validation perspective. Obviously, there are limitations to how much validation can happen.

But, definitely, we recognize the potential concerns and, as Andrew says, looking at the data over time to see where technical problems become mitigated over time and then recognizing those things were we to use any data from a time prior to that would become really important.

Also pointing out, again, that while we're certainly optimistic that the data that we do receive through this initiative will be very important in improving the accuracy of the value of the packages, we note that right now, the data that we have isn't quite as robust as it will be under this circumstance.

And so, additionally, the rate setting processes under the Physician Fee Schedule almost always include some degree of expert review. They certainly, by law, require public notice and comment rulemaking.

And, so, in combination of all of those things, we think that the having the data with the caveats and, particularly as we have more information about the specific problems, will

be certainly positive from a payment accuracy perspective and, at the same time, will be an iterative process that we'll continue to want to hear about the problems that are ongoing and how to best interpret the data for purposes of setting the rates.

Eric Whitacre: Thank you very much. If I could just add a second part to that, I do understand how the iterative approach will help address the issues of the mechanics within clearinghouses and/or EMRs. Part of my concern is – and not that there should be a punitive aspect to this – but part of my concern is motivating the surgeons to do this. Despite our best attempts at education, this may be difficult to do on a very short timeline.

It's sometimes difficult for the practicing surgeons to understand the details and the components of the RAC review and how post-operative visits are bundled into the value of their procedures. So it's possible that even though the iterative process will solve the issues of the mechanics of the reporting, if there's not adequate motivation – and, certainly, surgical societies need to be held accountable for that and I know the ACS is doing a lot – but I'm concerned that that won't – the iteration won't correct the surgeon understanding and motivation to report. But thank you very much for the opportunity to comment.

Ryan Howe: Sure. Thank you.

Operator: Our next question will come from the line of Allison Luallen.

Allison Luallen: Good afternoon. We put in the 99024 for every post-operative visit. I'm worried that our software isn't sophisticated enough to differentiate between CPT codes. So would it be okay if that's the case to report the 99024 on a CPT code that is not one of the required 293?

Ryan Howe: Yes. That's absolutely the case. So, one of the challenges that we recognized immediately with the limiting the required reporting was that it might be challenging for practitioners and for practices in general to be selective about when they're reporting and when they're not.

And sometimes that can be as administratively as complicated as sort of a blanket reporting requirement. And so, we recognize that as a potential data analysis concern and certainly something that we take into account. But reporting is optional not only for

practitioners in other states and fewer than – who are practicing in fewer than 10 groups but also for followup visits that are unrelated to one of the selected procedures.

Allison Luallen: Thank you.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Jean Heron.

Jean Heron: Hi there. I am questioning the – beginning on January 1st of the MACRA Section 523 for the G-codes to report post-op visits in global periods, is this – is the 99024 superseding that and we don't have to worry about these G-codes?

Ryan Howe: That is correct. The finalized policy is to report the 99024 under the circumstances that we've described in the call. I think what you're referring to is the – under the proposed rulemaking...

Jean Heron: Yes.

Ryan Howe: ... that we had proposed a series of G-codes that would describe the post-operative services in more detail.

Jean Heron: Yes.

Ryan Howe: And that would have been nationally required reporting. But, we – based on response to public comment, which we definitely appreciate, we did not finalize that proposed policy and, instead, finalized this one.

Jean Heron: Wonderful. Okay. Thank you. That was a concern of mine.

Leah Nguyen: Thank you.

Jean Heron: That's all. That's it.

Operator: Our next is going to come from the line of Judy Presson.

Judy Presson: Hi there. I have a question regarding the borders – going back to the border states and that we sort of have an opposite situation as the previous caller. We would be performing surgeries actually in a non-reportable state in Washington and some of our patients would be seen in Oregon in post-op – for post-op visit. And so our question is, is the requirement driven off of the location of the surgery?

Ryan Howe: So, the requirement is driven on the practice location. And so it sounds like in your scenario, the post-operative visits would be required reporting and the surgeries themselves would not. Of course, the surgeries have to be reported in order to be paid. So I'm not sure that the surgeries are unlikely to be reported themselves.

But in terms of the data analysis, again, we'll look at it in the context of the fuller range of Medicare claims data, which would include the surgeries, and then, recognizing that in border situations, that will certainly happen. But that's sort of the short answer, I guess.

Leah Nguyen: Thank you.

Judy Presson: Okay. Thank you.

Operator: Our next question will come from the line of Karl Ellzey.

Karl Ellzey: Hi, there. Thanks for taking the call. My question has to do with ICD-10 codes that are linked to 99024. Is it the original ICD-10 code that started the global services? And I understand if multiple services are being – or global visits are being performed on the same account for multiple procedures, do you need to link multiple ICD-10 codes to the 99024 or is just one required?

Ryan Howe: So, our current reporting requirements don't address the ICD-10 diagnosis coding. So, they should be consistent with other reporting requirements. I would imagine that the most helpful would be to link it to the same as the procedure if it is, in fact, a surgical post-op visit. If there's more than one, then, I think, from a data analysis perspective, the more information we have, the better. But, certainly, that would not be required.

Karl Ellzey: Great. Thank you.

Operator: Our next question will come from the line of Stacey Murphy. Stacey, your line's open. That question has been withdrawn.

Your next question will come from the line of Emmy Clancy.

Emmy Clancy: Hi. Thank you. I have a couple of different questions. The first one – you mentioned that the goal would be to get to a 12-month reporting period. Do we expect that this reporting will go through July of 2018?

Ryan Howe: So, as finalized, the reporting requirements has no end date, and I think that any change in the reporting requirement would be taken through notice and comment rulemaking. So, at present, the reporting requirement is from July 1st onward.

And the end date would be to be determined. I think you're probably referencing what Marge had said earlier.

Typically, when we use claims data for purposes of setting rates under the Physician Fee Schedule, we'd use a complete year. I think that was in response to any concerns about any more immediate ramifications on the setting of rates from the data collection. But, I don't know that that's necessarily relevant in terms of speculating or projecting about what the – ultimately the required reporting periods will be.

Leah Nguyen: Thank you.

Emmy Clancy: Okay. And would the required reporting period start with the surgical data service of July 1, 2018, or would we include post-op that might be linked to procedures prior to that start date?

Ryan Howe: So, the required reporting would be based on when the surgical procedure itself has a date of service on July 1st, 2017, or after. But, again, voluntary reporting or optional reporting would be available before that.

Leah Nguyen: Thank you.

Emmy Clancy: Okay. I do have two more questions or would you prefer I re-enter into the queue?

Leah Nguyen: Yes. If you could re-enter the queue, that'd be great. Just press star, one.

Emmy Clancy: Thank you.

Operator: Our next question will come from the line of Julie Deck.

Julie Deck: Yes. I have a question regarding the voluntary reporting of the 99024. Actually, our question is because our software would be able to – we want to know if we can report on surgery codes that are not on the list, if we can go ahead and voluntarily report the 99024.

Ryan Howe: Yes. You definitely can. And we'll take that into account when we analyze the data.

Leah Nguyen: Thank you.

Julie Deck: Okay. All right. Thank you.

Operator: Our next question will come from the line of Kelly Dean.

Kelly Dean: Hi. I had a question with regard to what are you guys looking for typical post-op visits after a surgery? Is there a certain number of post-op visits that one should be performing? You know, like is it supposed to be one every week during the post-op period or what type of followup schedule?

Ryan Howe: Thank you for the question. I think that's a question of medical practice and not coding or billing requirements. I think, if it's helpful context to understand, the – part of the way the global surgical packages on a procedure code level are valued is based on an assumption on the number of visits that are typical.

Kelly Dean: Okay.

Ryan Howe: And those assumptions are publicly available as part of our rate-setting files for all of the 4,000 global surgery codes, what assumptions we're making that sort of go into the underlying data. But I would caution there that those assumptions are not necessarily indicative of what medical practice may indicate, particularly not for an individual patient.

And so, I would say that those numbers are available and they're – that's what is used for rate-setting purposes. But they are in no way meant to be instructive or anything like that.

Kelly Dean: Okay. Thank you very much.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Jene Skelly.

Jene Skelly: Hi. Good afternoon. I'm just wondering how long we will have to file the 99024 as far as your data collection. Will you allow us 1 year to get those visits in from the date that they happened? We're looking as this as perhaps having to be a project just because of how the physicians are not used to reporting particularly their hospital post-op visits. So, we may have to go back in and find those.

Ryan Howe: So, I think in general that the timely rules would apply. And again, we certainly understand that the initial implement of the required reporting may have some significant lag times for different practices, depending upon the technical needs as well as the changing operating procedures.

And so, we certainly wouldn't use that data immediately. I don't think there's any interest in sort of looking at the first 3 months of data and making important decisions based on that given all of the challenges that we know that the practitioner community faces.

Jene Skelly: Great. We appreciate that. Thank you.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Stephen Metz.

Stephen Metz: Hi. Thank you very much for taking the question. In our group, it is not uncommon for a specialist from another, you know, specialty to provide consultative services. For example, if we have an infectious disease problem, to consult in. How do you handle that visit?

Ryan Howe: So, I'm assuming that you mean during the post-operative period there may be a consultation with the patient from a related specialist?

Stephen Metz: From an unrelated specialist but one in our group.

Ryan Howe: Oh, right, okay. So related from a business perspective but not from a – got it. So, I think, in that case, you would report the 99024 if you wouldn't otherwise report only because of the global package, meaning that if you would report that patient interaction, if that other specialist would report under current practice an E&M visit, say, an office outpatient visit, then you should – that individual should continue to report that office or outpatient visit and be separately paid for it. If that patient interaction happens and would not be reported because of it being included in the global package at current, then under those circumstances, then the 99024 should be reported.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Betty Osborn.

Betty Osborn: Thank you for taking my call. My question relates to visits that may happen during a post-operative period in which both the followup for the original surgery is addressed and additional problems are also addressed.

In today's world, we bill an E&M for that and indicate by modifiers that it's an unrelated visit. Do you also, in that case, want us to submit a second code for a post-operative visit since some part of the care during that visit was related to the post-op problem?

Ryan Howe: So, let me just make sure that I – that we understand the question fully. So, ordinarily, what you would do in that circumstance, you'd bill an E&M code, say an office visit code, with a modifier to show that it's outside of the global period.

Betty Osborn: Correct.

Ryan Howe: I think that right now, you wouldn't report that because you wouldn't report two E&Ms in the same day.

Betty Osborn: Thank you.

Ryan Howe: Yes.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Vinita Ollapally.

Vinita Ollapally: Hi. This is Vinita Ollapally with the American College of Surgeons. Thanks for having this call. My question relates to the definition of a group. So, on slide 10, a group – the group definition is listed here. And this is different from how Medicare typically defines groups as TINs. So my question is why this definition was used instead of a TIN. I think that we've been getting questions from our members, and TINs are typically easier to understand.

And then, my corollary question to this is on slide 15, at the top, there is a definition of, in the case of post-op care being transferred, then the TIN is what is used.

So, just so I understand, in defining a group, it's the definition on 10 that should be used. But then once a group has been determined to be large enough, then if care is transferred, then we would look to the TIN. Is that correct? And if not, would appreciate some clarification.

Ryan Howe: Thank you. That's a great question, Vinita. I think – so, I think it's important to remember that in terms of the practice size, what we're trying to do in terms of defining it for required reporting purposes is to identify from a burden perspective, where there are operating practices that have the infrastructure, where the burden for reporting would be lessened relative to smaller practices where that burden would be particularly problematic. And that's based on the comments, of course, during the proposal.

So, in terms of the use of TIN in the transfer of care, I think we're trying to capture what the current billing rules are regarding the transfer of care.

And so, the disconnect – it's a fair point. But we think that it's important that in order to both maximize the different kinds of practices and the different kinds of settings that we're getting data from in terms of the post-operative visits while at the same time minimizing the burden on practices that really are small in a way that will be particularly

problematic, that we use different definitions. So – and we can certainly tease this out more if you want to followup.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Ariana LeBlanc.

Ariana LeBlanc: Hi, and thank you. We have a number of critical access hospitals that operate provider-based clinics and follow a Method II billing requirements. So that means that our pro fees are submitted on UB claim forms along with any hospital charges. My question is whether this reporting requirement applies to critical access hospitals and provider-based clinics. And if so, is there a specific revenue code that should be reported along with the 99024?

Ryan Howe: It's a great question. Thank you for asking it. So, in terms of the reporting requirements, there's nothing in the policy that would exempt CAHs who are reporting under, say, CAH Method II, from reporting, assuming that the professional is operating in a group of 10 or more as a practical matter and in a state that is required to report.

As to the revenue code, again, I apologize, but I guess, predictively, I'm going to have to – we'll take that as a note and certainly get back to you and add that to the frequently-asked questions to make sure that the folks who are billing that way have all of the appropriate information.

Leah Nguyen: Thank you.

Ariana LeBlanc: Thank you.

Operator: Our next question is going to come from the line of Steve Becker.

Steve Becker: Thank you for taking my call or question. I'm with a large multi-specialty group here in Boca Raton, Florida. And we bill out the post-op visits literally hundreds of times per month. So my question is, if we're doing everything compliantly and documenting appropriately, are you really asking us to do anything differently with this program?

Ryan Howe: It doesn't sound like it.

Steve Becker: Yes. Okay. Thank you.

Ryan Howe: Sure.

Operator: Our next question will come from the line of Dana Freeman.

Dana Freeman: Hello. We would like to know when we report the 99024, should we be using the surgical diagnosis code or the status post code?

Ryan Howe: Again, I think we answered a question similar to this. And initially, I think our thought is that it should be related – it should be the surgical code. But we'll add that to our list and talk with the diagnosis code specialists.

As you're probably aware, those of you billing on the professional claims, the diagnosis coding is used more extensively in an institutional setting.

And, so, the folks that you have here at CMS are in the room right now are the professional billing folks. And so, we'll – we will consult with our colleagues and make sure to answer that question with greater accuracy.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Monica Soles.

Monica Soles: Hi. Thank you. We wanted to clarify, if a physician is seeing a patient in the hospital post-op day 1 or day 2, do they still bill for that 99024 or report it?

Ryan Howe: So, if the – any visit in the hospital setting that would outside of a global period be separately reportable using an E&M code, like a subsequent hospital care code, should be reported using the 99024.

Monica Soles: Okay. Just to clarify, so they would be seeing them post-op Day 1, which is global. Does that get reported as a 99024?

Ryan Howe: So, the day after the procedure or the day of the procedure?

Monica Soles: The day after the surgery, they would be seeing them prior to discharge.

Ryan Howe: Right. That would be reported as a 99024.

Monica Soles: Okay. Thank you.

Ryan Howe: Sure.

Operator: Thank you. Your next question will come from the line of Nichole Mast.

Nichole Mast: Yes. I just wanted to clarify on slide 7 when it states who is required to report, I am – I work for a one-physician practice located in Tampa, Florida, and I wasn't sure if he is still required, because we're in the state of Florida, to report these codes.

Ryan Howe: No. The reporting requirement is limited to those that meet all of the conditions in terms of both practice size and geography and furnishing those particular procedure codes. So, all of those need to be met. So, if – even single practitioners in Florida would not need to report.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Laura Tanigawa.

Laura Tanigawa: Hi. My question is going back to those secondary claims. I just want to make sure that – I mean not secondary, but the posting of these zero-dollar claims. I mean, that's going to be a lot. And so, they will have to make sure, you know, if it's going to be a contractual adjustment or another adjustment. And, then, is there a way to stop that from automatically going over to the secondary?

Ryan Howe: I'm afraid that's probably a billing question that we certainly appreciate and, unfortunately, don't have the right folks right here in the room. I do think the precedent that we've considered from an agency perspective is a lot of the other reporting requirements that are used for HCPCS codes. So, some of the quality reporting as well as the therapy functional reporting requirements, etc. – and, so, the same general models will be used.

Laura Tanigawa: All right. A lot of extra work.

Leah Nguyen: Thank you.

Laura Tanigawa: Thank you.

Operator: Our next question will come from the line of Stacey Murphy.

Stacey Murphy: Yes. Hi. Good afternoon. I work at the VA Hospital and I heard one of the – looking at one of the slides, you mentioned something about is this required for VA patients, but I must have missed the answer. So I just wanted clarity. Are we required to use the 99024 for patients that are seen at the VA Hospital?

Leah Nguyen: Hold on one moment.

Ryan Howe: So, thanks. That's a great question. Again, reporting's only required for traditional Fee-for-Service Medicare patients and it's also required when Medicare is the primary payer for the global procedure.

Stacey Murphy: The primary payer. Okay.

Ryan Howe: Right.

Stacey Murphy: So, then, I – Okay. Yes. So, then, I guess, in the VA, since we don't bill Medicare, then it would not apply to VA.

Ryan Howe: Right.

Stacey Murphy: Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Regina Currimbhoy.

Regina Currimbhoy: Hello. I just wanted to confirm. Maybe you all answered this question already, but I wanted to know if the 99024 code should be used even when doing post-op phone calls.

Ryan Howe: So, again, 99024 should only be used when otherwise an evaluation and management visit code would be used if outside of a global period. So, telephone calls generally are considered bundled services and so wouldn't be separately reported.

And, so, for those reasons, you would not report a 99024.

Leah Nguyen: Thank you.

Regina Currimbhoy: Thank you.

Operator: Our next question comes from the line of Emmy Clancy.

Emmy Clancy: Hi. Thank you. I had two additional questions and both may go into that already asked and answered, but I do want to be much a little bit more specific than I've heard in previous questions. The first is regarding a multi-specialty practice where you may hit the mark as far as geographical location and 10 providers but perhaps only one or two are actually surgeons.

And, normally, when we apply Medicare, you know, we talk about same provider would be same specialty, same tax ID. And we've already discussed how the TIN isn't necessarily the marker here and how the NPI isn't. But in the case where it really is limited as far as the specialties that would report surgical procedures and then global followups, I'm assuming we'd still apply. But, I want to ask that to make sure.

Ryan Howe: Yes, no, it's a really good question and I appreciate the specificity. So, yes, there would still be requirements to report. Depending upon the business model and the interaction with patients, of course, there are certainly circumstances where we believe that in practices there are cases where the non-surgeons seeing the patient for a post-operative global visit – and we would want to make sure to capture that information.

And, so, that's the reason for that reporting requirement there. I'd also note that of the several hundred codes, some are relatively minor office-based procedures, particularly the ones that have 10-day global periods. And so, it may not be just the traditional surgeons who are furnishing some of the procedure codes in some cases.

Leah Nguyen: Thank you.

Emmy Clancy: Okay. Thank you. And then, the second question is specific to, in a followup period where the patient might be coming up for a 99024-appropriate service but then the complications or other identifiable – separately identifiable services may

be rendered such that would require an E&M code with the modifier 25, do you still want the 99024 in addition to the E&M-25 because that was the original intent of them coming in the door?

Ryan Howe: Right. So under those circumstances, no, we would just want the E&M code with the appropriate modifier. The reason for that being is that you wouldn't report a separate E&M code – two separate E&M codes on the same day.

And the – for simplicity's sake in what can be a confusing circumstance, we want to make it clear that the reporting of the 99024 should only happen in circumstances where, were it not for the global period, a separate E&M code would be billed. And under the circumstance that you described, the second E&M code wouldn't be billed in addition to the first one.

Leah Nguyen: Thank you.

Operator: Our next question comes from the line of Linda Barney.

Linda Barney: Hello. Am I live?

Operator: Yes. Go ahead.

Linda Barney: If the goal is to capture all the post-operative work, why only report 99024 for one, such as if a patient has visits or multiple higher level visits global post-operative 24-hour period; also the issue with discharge dates and…

Ryan Howe: I have to apologize. We had a hard time hearing you. And, so, I don't know if there's something you can do to make the question more clear. I certainly heard some of it and could try to answer it. But I want to give you the opportunity to articulate it more clearly, cleanly.

Linda Barney: Sorry. So if all of the post-op work is to be captured, why only report 99024 once in the post-operative period?

Ryan Howe: Great. That's a good question. So, the goal in the reporting requirements and the policy is to report 99024 for the number of visits. So, in other words, the

number of times in the post-operative period than an evaluation and management code would be billed.

So that would be if the patient were seen three times in the 90-day global period, then the goal would be to have three 99024s reported, assuming that those three encounters would have otherwise been reported using the E&M codes on those three separate instances. I hope that answers your question.

The only other thing that I'd add is that while we certainly recognize that there's the potential – and expect that there is, in fact, additional work in addition to the face-to-face visits, and some of the proposed G coding got at some of that other work – but we recognize that requiring reporting on some of that other work was a really valid concern from commenters in terms of the burden of reporting on all of that work.

We also wanted to note that the – part of the multi-faceted approach where we are also conducting a survey and doing direct observation is to get at what other kinds of effort and resources are being deployed in the post-operative period, including all of the other works. So, again, this claims-based reporting is only one piece of a bigger picture.

Leah Nguyen: Thank you.

Linda Barney: Great. Thank you.

Operator: Our next question will come from the line of Cherie McNett.

Cherie McNett: Hi. This is Cherie McNett with the American Academy of Ophthalmology. I have a question related again to the practice size. So if there's a practice that has optometrists that are part of the practice but they only do – they only work like in the related optical shop and they don't see patients for other reasons, should they be counted as part of the group?

Ryan Howe: So as a general principle, the practitioners who could independent – who are qualified to independently bill who work in a practice should be counted. So, whether or not they independently bill for their services or their services are billed, say, incident-to or something like that isn't material for purposes of – from a practical matter counting the size of the practice for purposes of requiring the reporting.

Leah Nguyen: Thank you.

Cherie McNett: Okay. Thank you.

Operator: Our next question will come from the line of Katie Smith.

Katie Smith: Hi. I have a question in regards to our group of hospitalists billing. Unfortunately, there's no way for our providers to know what the surgeons are billing in regards to those 293 codes. So, how would our providers report that 99024 if, we're not exactly sure what CPT codes those surgeons are reporting? They're not specifically in our group.

Ryan Howe: So just to understand the question – to make sure that we understand the question, so under your circumstance, there's a surgeon in a hospital reporting a procedure code and it may or may not be one of the 300 or so codes. And then, in terms of the followup visits, you'd be billing for the professionals who are seeing the patients for the followup care. Is that right?

Katie Smith: Correct. We actually service sometimes the medical portion for, like, maintenance of diabetes, hypertension, things of that nature that could be a potential flare-up after surgery. So, we're not specifically clear as far as when we need to be reporting this, if we need to be reporting this, because we're unaware of specifically what CPT code those surgeons are billing. And how would we know that?

Ryan Howe: Okay. That's a great question. I'm not sure that offhand we have the answer for that. But it's certainly something that we can consider and we will definitely address. I would point out that the codes – the several hundred codes that are on the list were prioritized based on the frequency of which they're furnished.

And, in fact, they represent the bulk of the 4,000 different procedure codes. And, so, while that's not a perfect answer, certainly directionally, that might be helpful to know that the goal is to capture most of the services and exempt the sort of unusual services but to capture the information on the most commonly furnished ones.

Again, we understand that that may prove to be a challenge in this case, in the specifics in terms of which code is billed. But in general principle, I think the expectation would

be that you would be required to report. But on a case-by-case basis without knowing the code, I think that's an interesting question, and we'll think about that.

Katie Smith: Okay…

Leah Nguyen: Thank you. If you want to email that in, there's an address on slide 13.

And, Holley, it looks like we have time for one final question.

Operator: Okay. Our final question will come from the line of Stacey Murphy.

Stacey Murphy: Yes. I'm sorry. Stacey Murphy again from VA Hospital. I forgot to ask my other question. It's pertaining to, I believe, slide 11. I just wanted to just clarify that it's okay to report 99024 multiple times though, let's say, for example, because I also do training on the outside for providers that work in a hospital setting, they're like hospitalists and they might round on their patients after they do their surgery. So, let's say the patient's in the hospital for 7 days and they go, like, every odd day or every even day. We would still report this 99024 for each day that they see the patient after surgery?

Ryan Howe: Right. So the goal of the required reporting of 99024 is to report under circumstances when, were it not for the global period, the visit would be reported using an E&M code. And under ordinary circumstances, if the practitioner would report, say, a subsequent hospital care code, then because of the global period, they would report the 99024.

Stacey Murphy: Okay. Perfect. Thank you very much.

Ryan Howe: Thank you.

Additional Information

Leah Nguyen: Thank you.

Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on slide 13 of the presentation. An audio recording and transcript of today's call will be posted to the MLN Connects Call website.

See slide 27 of the presentation for a link to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connects Call on global surgery. Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

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