Global Surgery Data Collection as Required by PAMA & MACRA

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Objectives

Attendees will learn the following:
- Why this data is being collected
- Alternative methods considered
- How the federal government plans to use the data
- How the data could impact future reimbursement
- Who must comply with these requirements
- What happens if one does not comply
- What must be submitted
- Possible impacts to provider and coder productivity
- Possible changes to billing system functionality
Global Surgery Package in a Nutshell

• Certain services under the Medicare PFS are valued and paid for once as part of a package
• CMS makes a single payment for serviced assumed to be typically furnished during the global period
Background

• PAMA authorizes the HHS Secretary to collect information on resources directly or indirectly relating to furnishing services for which payment is made under the PFS

• The HHS Secretary was also afforded permission to use the information collected or obtained in the determination of relative values for services under the PFS

• However, if the HHS Secretary uses this information, the source and use of the information has to be disclosed through notice and comment rulemaking
Identification of Misvalued Codes

• experienced fastest growth
• experienced substantial changes in practice expenses
• describing new technologies or services within an appropriate time period
• multiple codes that are frequently billed in conjunction with furnishing a single service
• have low relative values, particularly those that are often billed multiple times for a single treatment
• have not been subject to review since implementation of the fee schedule
• account for the majority of spending
Identification of Misvalued Codes

• services that have experienced a substantial change in the hospital length of stay or procedure time
• there may be a change in the typical site of service since the code was last valued
• a significant difference in payment for the same service between different sites of service.
• there may be anomalies in relative values within a family of codes
• services where there may be efficiencies when a service is furnished at the same time as other services
• high intra-service work per unit of time
• high practice expense relative value units
• high cost supplies
Background

• Problems with accurate valuation of 10- and 90-day global packages discussed in CY 2015 PFS Proposed and Final Rules
• CMS finalized policy to transform all 10-day and 90-day global codes to 0-day global codes in CY 2017 & CY 2018
• 0-day global code change overturned by MACRA
Background

• MACRA signed into law on April 16, 2015
• 0-day global code change overturned by MACRA
Stakeholder Input

• CMS Listening Session
CMS requested recommendations on how best to collect number and level of post-operative visits
2017 Proposed Rule 3-Pronged Approach

• Claims-based reporting on the number and level of pre-and post-operative visits

• A survey of a representative sample of practitioners about the activities involved in and resources used in providing pre-and post-operative visits

• A more in-depth study including direct observation in a small number of sites, including ACOs
Postoperative Care

• Focus of global surgery valuation is on post-operative care
Claims-based Method

• CMS proposed that the G-codes would be reported for services related to and within 10- and 90-day global periods for procedures furnished on or after January 1, 2017.

• Services related to the procedure furnished following recovery and otherwise within the relevant global period would be required to be reported.

• These codes would be included on claims filed through the usual process.
Survey

• Collect information on the activities, time, and resources involved in furnishing pre-and post-operative visits from practitioners

• A representative sample across multiple specialties
Direct Observation

• Small number of sites
• Inform survey design
• Validate survey results
• Collect information not amenable to survey based reporting
Claim Reporting – Proposed Rule

• Inpatient
  GXXX1  Inpatient visit, typical, per 10 min.
  GXXX2  Inpatient visit, complex, per 10 min.
  GXXX3  Inpatient visit, critical illness, per 10 min.

• Office or Other Outpatient
  GXXX4  Office or other outpatient visit, clinical staff, per 10 min.
  GXXX5  Office or other outpatient visit, typical, per 10 min.
  GXXX6  Office or other outpatient visit, complex, per 10 min.

• Via Phone or Internet
  GXXX7  Patient interactions via electronic means by physician/NPP, per 10 min.
  GXXX8  Patient interactions via electronic means by clinical staff, per 10 min.
Stakeholder Input

• Town Hall Meeting
Claim Reporting – Final Rule

- Implementation date pushed back to 07/01/2017
- Associated global surgery codes streamlined
- Determined which providers would be required to report
- Decided on code to report
Claim Reporting – Final Rule

• Post-op visit code 99024 only needs to be reported if visit if related to selected surgical codes
• List of selected surgical codes is attached to this slide deck
Claim Reporting – Final Rule

• Report 99024 for related post-op visits
• Reporting not required for pre-op visits
• Continue using modifier 24 for unrelated visits during post-op
Claim Reporting – Final Rule

• Physicians and practitioners required to report if in group practice of 10 or more providers
Definition of Practice

• Group defined by TIN
• Practitioners whose business or financial operations, clinical facilities, records, or personnel are shared by two or more practitioners
• Do not necessarily need to share same physical address
• All physicians and qualified nonphysician practitioners that furnish services as part of the practice should be included to determine whether 10 or more practitioners are in the practice
• Do not count practitioners under short-term, locum tenens arrangements
• Can adjust time if practitioner works for multiple practices
Adjusting Time for Multiple Practices

• Aggregate all members of the group
• If sum = 10 or more FTE, then must report
• If sum = < 10 FTE, then not required to report
### Adjusting Time for Multiple Practices

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<td><strong>TOTAL FTEs</strong></td>
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<td><strong>TOTAL FTEs</strong></td>
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Claim Reporting – Final Rule

• Only practitioners in certain states required to report

And the lucky winners are...

Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island
Claim Reporting – Final Rule

• Can report 99024 on a rolling basis

or

• Can report all post-op visits on one claims
Documentation

• Documentation is required but does not need to be as detailed as that which would be required for an E/M service separately billable under the PFS
Unrelated Visits

• Append with Modifier 24
• Must apply E/M guidelines
• Documentation must support that visit is unrelated to the diagnosis for which the surgical procedure was performed and visit is not to treat/manage a complication
Impact on Teaching Physicians

• Teaching physicians subject to the reporting requirements in the same way that other physicians are.

• Use existing Medicare rules that teaching physicians use in reporting services in which residents are involved.

• Teaching Physicians should report CPT code 99024 only when services furnished would meet the general requirements for reporting services and should use the “-GC” or “-GE” modifier as appropriate.
Telemedicine

• Append “GT” modifier to 99024 procedure code
Mandatory Participation

- CMS is authorized to penalize providers 5% for noncompliance
- CMS will not apply financial penalties at this time
- CMS thinks reporting is beneficial
Provider and Coder Productivity Impact

• Appropriate diagnosis must be submitted with the claim
Billing System Changes

• Must be able to submit zero dollar charge
Not Done Yet

• Beginning in CY 2019, CMS must use the information collected, along with other available data, to revalue and refine the payment amounts for surgical services paid under the PFS.
Questions