Centers for Medicare and Medicaid Services Global Period Data Collection Effort

Frequently Asked Questions

As you may know, when surgical codes are valued, the total physician time and effort spent providing the surgery and the pre and post-op visits are considered. For example, for CPT 66982, in the valuation process it was assumed that for the typical patient there are 4 evaluation and management services that are provided in the pre and post-operative period. For the past several years, CMS has been concerned that the number of pre and post-operative evaluation and management services included in the valuation for certain services may not be accurate. In 2014, CMS attempted to do away with global periods entirely, so that a surgical service would be reimbursed separately from any pre and post-operative care provided. However, Congress intervened, and prohibited CMS from moving forward. Instead, Congress required CMS to develop a process to gather data needed to better value surgical services and post-operative care. CMS is now launching a data collection effort and your state will be impacted. We hope that the information below will be helpful and we encourage you to share this information with doctors in your state.

What are global periods?

Under the Medicare Physician Fee Schedule, surgical services are valued and paid for as part of "global periods" that include the procedure and the services furnished in the periods immediately before and after the surgical procedure. Surgical services are grouped into Minor Surgery (10 day post-operative period) and Major Surgery (90 day post-operative period). CMS will be measuring the number of services delivered during the global period for certain high volume procedures both Minor and Major Surgery.

Am I required to report?

This depends on your state; the size of your practice and if you report any of the codes that have been identified as triggering an additional data reporting requirement.

- If you practice in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon or Rhode Island AND
- Work in a practice with 10 or more practitioners (including non-physician practitioners)AND
- Deliver post-operative care to a patient for the CMS specified surgical services,

What am I required to report?

If you are in one of the impacted states, you work in a practice with 10 or more practitioners and you provide post-operative care for one of the CMS specified surgical services, you will have to report CPT 99024 (Postoperative follow-up visit) for each post-operative care visit provided during the global period for these services starting on July 1, 2017.

When are these reporting requirements going into effect:

July 1, 2017

What procedures require reporting?

Post-operative services related to certain surgical services require reporting. This includes about 30 eye-care related codes. The selected procedures were chosen because they are high-volume procedures for Medicare – they are furnished by more than 100 practitioners and either are nationally furnished more

than 10,000 times annually or have more than $10 million in annual allowed charges. The full list can be found here.

The eye-care related codes include post-operative care related to:

65756	Corneal trnspl endothelial	67145	Treatment of retina
65855	Trabeculoplasty laser surg	67210	Treatment of retinal lesion
66170	Glaucoma surgery	67228	Treatment x10sv retinopathy
66179	Aqueous shunt eye w/o graft	67255	Reinforce/graft eye wall
66180	Aqueous shunt eye w/graft	67800	Remove eyelid lesion
66711	Ciliary endoscopic ablation	67840	Remove eyelid lesion
66761	Revision of iris	67900	Repair brow defect
66821	After cataract laser surgery	67904	Repair eyelid defect
66982	Cataract surgery complex	67917	Repair eyelid defect
66984	Cataract surg w/iol 1 stage	67924	Repair eyelid defect
67036	Removal of inner eye fluid	68760	Close tear duct opening
67040	Laser treatment of retina	68761	Close tear duct opening
67041	Vit for macular pucker	68801	Dilate tear duct opening
67042	Vit for macular hole	68810	Probe nasolacrimal duct
67108	Repair detached retina	68840	Explore/irrigate tear ducts
67113	Repair retinal detach cplx		

Does this change how I code for patients for which I am co-managing care following surgery>?

CPT 99024 would need to be reported for each date of service during the global period. This will be done in addition to the surgical codes you reported, with appropriate modifiers, as needed.

What will happen if I fail to report this data?

At this time, there is no penalty for failure to report in 2017. However, if compliance proves to be a challenge, CMS has statutory authority to withhold five percent of the physician fee schedule payment for non-compliant practitioners. This would require future rulemaking and a public comment period.

What else is CMS doing to better value global packages?

CMS will be performing a survey of practitioners to gather data on services furnished in the post-operative period, in addition to collecting practitioner data based on CPT codes.

What is the long-term impact of this data collection?

The data collected will either support or conflict with the present estimate of the amount of physician work expended in the delivery of a given service. Ultimately, this data collection is likely to result in the revaluation of certain surgical CPT codes. The AOA will remain involved in the revaluation process if and when it proceeds and will keep you informed of any future changes.

What if I have more questions?

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