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June 2025 | A-05-20-00021

CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries

REPORT HIGHLIGHTS

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CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries

Why OIG Did This Audit

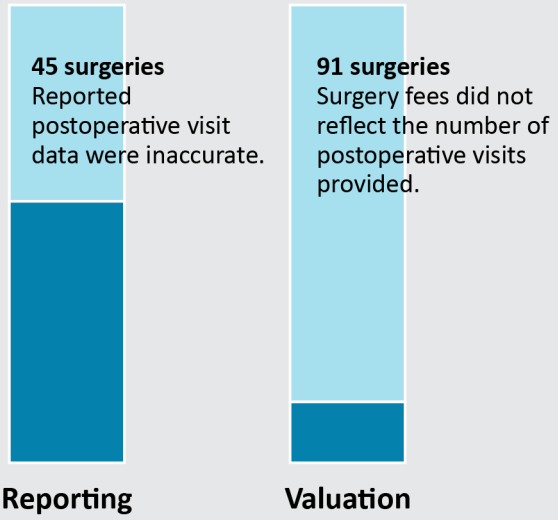
- Under Medicare's global surgery policy, CMS bundles into a single payment those services normally furnished by a practitioner before, during, and after a procedure, such as postoperative visits.
- Prior OIG work raised concerns that CMS may not have been valuing global surgeries appropriately.
- As part of the Medicare Access and CHIP Reauthorization Act of 2015, Congress mandated that CMS gather information from physicians to assist in improving the accuracy of global surgery valuation, and that we audit a sample of that information needed to value global surgeries to verify its accuracy.

What OIG Found

Although practitioners are not required to provide Medicare patients the number of postoperative visits that CMS considered in valuing the global surgery fee, based on our sample results, we discovered that overall, fewer visits are provided than are considered in the valuation. We estimated that Medicare paid a net $5.7 million more and that Medicare patients paid a net $1.7 million more than would have been paid if global surgery fees reflected actual utilization of postoperative visits.

Postoperative visit data CMS gathered for 45 of 105 sampled global surgeries were inaccurate and cannot assist in improving global surgery valuation as Congress intended. Improving global surgery valuation is still needed, as we identified that the fees for 91 of 105 sampled global surgeries did not reflect the number of postoperative visits provided.

Of **105** randomly sampled global surgeries:



What OIG Recommends

We made five recommendations to CMS, including procedural recommendations to address improving the accuracy of postoperative visits reported by practitioners and updating the global surgery fees to reflect the number of postoperative visits actually being provided to Medicare patients. The full recommendations are in the report.

CMS concurred with one of our recommendations but did not indicate either concurrence or nonconcurrence with the remaining recommendations. In addition, it detailed steps it has taken and plans to take in response to our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

A global surgery package, or global surgery, is a group of clinically related services, including the surgical service and related preoperative and postoperative visits, that are treated as a single unit for coding, billing, and reimbursement. Under Medicare's global surgery policy, the Centers for Medicare & Medicaid Services (CMS) bundles into a single payment all necessary services normally furnished by a practitioner before, during, and after a procedure in a timeframe known as the global period.[1]

Prior Office of Inspector General (OIG) work raised concerns that CMS may not have been valuing global surgeries appropriately.[2] In response to our concerns, CMS planned to change all global surgeries to include reimbursement for necessary services on the day of surgery only and pay practitioners separately for preoperative and postoperative visits. As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress halted CMS's proposed change and mandated that CMS gather information from physicians to assist in improving the accuracy of global surgery valuation.[3] To comply with MACRA, CMS began to require that practitioners in 9 States (reporting States) who are part of medical practices with 10 or more practitioners report their postoperative visits for specific global surgeries with dates of service on or after July 1, 2017.[4, 5, 6] CMS also encourages practitioners in practices with fewer than 10 practitioners to report their postoperative visits, if feasible. From January 1 through March 31, 2018, Medicare paid $306.4 million for 1.3 million of these specific global surgeries in the reporting States.

Congress also mandated that OIG audit a sample of the information needed to value global surgeries that CMS gathered to verify its accuracy. This report contains the results of our

[1] The global period includes the day of the procedure and the 10-day postoperative period for minor surgeries and the day prior to the procedure, day of the procedure, and 90 days following the procedure day for major surgeries.

[2] See Appendix B for related OIG reports.

[3] CHIP is an acronym for the Children's Health Insurance Program.

[4] For the purposes of reporting to CMS, practitioners include physicians and nonphysician practitioners such as physician assistants and nurse practitioners who are permitted to bill Medicare under the Physician Fee Schedule.

[5] These nine reporting States are Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island.

[6] CMS selected the nine reporting States by grouping States according to the number of Medicare enrollees and selecting States from each group at random. After each group's selection, CMS removed the States in the same Census Bureau region from the remaining groups for which selection was pending to maximize the geographic variation in the selection of States.

congressionally mandated audit of global surgery information.[7] We are separately conducting a related audit covering surgeries for which CMS expected postoperative visits to be provided but none were reported.

OBJECTIVES

Our objectives were to determine:

1. the accuracy of the number of postoperative visits practitioners in reporting States reported to CMS and
2. whether the global surgery fees reflected the number of postoperative visits that these practitioners provided to Medicare patients during the global period.

BACKGROUND

The Medicare Program

The Medicare program provides health insurance coverage to people aged 65 and older, people with disabilities, and people with end-stage renal disease. CMS administers the program. Medicare Part B provides supplementary medical insurance for medical and other health services. CMS contracts with Medicare Administrative Contractors (MACs) to process and pay Part B claims.

Medicare Part B Physician Fee Schedule

Medicare Part B pays for covered physicians' services, including global surgeries and evaluation and management (E/M) visits,[8] provided to patients enrolled in Medicare Part B. Section 1848(b) of the Social Security Act (the Act) requires Medicare to pay for physicians' services based on an established fee schedule that CMS updates annually. Practitioners participating in the Medicare program must accept the fee schedule amount as payment in full.[9]

As part of CMS's process for determining the fee schedule amount, CMS determines the relative value of physicians' services. To do so, CMS quantifies the resources typically involved with furnishing each service compared to other services.[10] A physician service that requires greater resources is assigned a higher relative value that will result in a higher fee schedule amount.

[7] The global surgeries included in this audit had at least one postoperative visit reported.

[8] E/M visits are nonsurgical services provided to diagnose and treat diseases or counsel and evaluate patients.

[9] Medicare pays up to 80 percent of the fee schedule amount after satisfaction of any deductible, and the Medicare patient pays any deductible amount, as well as up to 20 percent of the remaining fee schedule amount.

[10] CMS establishes the relative values of physicians' services by considering physician work, practice expenses, and malpractice insurance (42 CFR § 414.22).

Section 1848(c)(2)(B) of the Act requires CMS to review the relative values used in calculating physician fees at least every 5 years. CMS is also required to adjust fees as it deems necessary to account for such developments as medical practice or coding changes, new data, or new procedures.

Global Surgery Fees

CMS has a global surgery policy to bundle payment for pre-, intra-, and postoperative services.[11] When assigning the relative value for a global surgery, CMS considers the resources typically needed during the global period, which includes any preoperative and postoperative visits.[12] CMS publishes the number and type of E/M postoperative visits in the Physician Time File that it considers in valuing each global surgery fee.[13] CMS does not require nor expect practitioners to provide the typical number of visits considered in valuing each global surgery fee, as patients' postoperative care needs may differ from the typical case.[14] The global surgery payment does not vary if more or fewer postoperative visits are needed for patient care than the typical amount that CMS considered when valuing the global surgery fee, but CMS believed that the amount of postoperative care will average over time and the patient population.

Medicare's global surgery fee includes payment for services related to the surgery when performed by the practitioner furnishing the initial procedure and by other practitioners in the same group practice and specialty. These practitioners may not bill and receive separate payment for services related to the procedure within a global period. Practitioners may, however, bill and receive separate payment for services unrelated to the procedure by using a modifier to indicate that the service is unrelated.[15]

[11] 42 CFR § 414.40(b)(1).

[12] In assigning the relative value for each global surgery, CMS relied in part on surveys completed by practitioners who perform the procedures for certain specialties. The surveys include a description of a typical patient for the procedure being surveyed. Practitioners complete surveys using their experience on what services would be needed for the described typical patient, including the number of postoperative visits. Until CMS required reporting of claims data on July 1, 2017, CMS did not have any information about the postoperative visits actually furnished. CMS has not used the postoperative visit data collected since July 1, 2017, to update the global surgery fees.

[13] The Physician Time File is posted annually with the Medicare Physician Fee Schedule on CMS's website. It contains physician or clinical staff times for more than 7,000 different procedure codes, including global surgeries. For global surgeries, it lists estimates of physician time for the entire global service and for the preservice, intraservice, and the immediate postoperative components of the global service.

[14] CMS recognized that not all patients require the same amount of postoperative care. The global surgery payment is based on typical work, but CMS intended for it to cover both easy and difficult cases, as some patients will require more than the usual amount of care and other patients require less than the usual amount of care.

[15] Modifiers indicate that a service or a procedure performed has been altered by some specific circumstance but not changed in its definition or code. They are used to add information or change the description of service to improve accuracy or specificity.

CMS classifies global surgeries based on the number of postoperative days, which may be 0 (day of the procedure), 10, or 90 days. CMS refers to 10-day procedures as "minor surgeries" and 90-day procedures as "major surgeries."

CMS's Claim-Based Data Collection Policy

Section 1848(c)(8)(B) of the Act, added as a result of MACRA, required CMS to develop and implement a process to gather information needed to value surgical services, including the number and level of medical visits furnished during the global period, reported on claims or in another manner. MACRA also required CMS to use the information reported using the new process to improve the accuracy of global surgery valuation.

In the Medicare calendar year (CY) 2017 Physician Fee Schedule Final Rule, CMS finalized its claim-based data collection policy (referred to in this report as "data collection policy").[16] CMS required practitioners who work in practices that include 10 or more practitioners in reporting States to report on certain procedures furnished on or after July 1, 2017. The data collection policy requires these practitioners to report Current Procedural Terminology (CPT®)[17, 18] code 99024 on claims for postoperative visits furnished during the global period of certain global surgeries specified by CMS (referred to in this report as "CMS-specified global surgeries").[19, 20] CPT code 99024 is a nonpaid code described as a postoperative followup visit, normally included in the surgical package, to indicate that an E/M service was provided during a

[16] 81 Fed. Reg. 80170, 80209-80225 (Nov. 15, 2016).

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[19] For reporting requirement purposes, practices are defined as a group of practitioners whose financial operations, clinical facilities, records, or personnel are shared by two or more practitioners; such practices do not need to share the same physical address. All physicians and qualified nonphysician practitioners that furnish services as part of the practice should be included in the count if they share a facility and other resources, regardless of how they bill Medicare.

[20] At the time of this report's issuance, CMS continues to collect CPT code 99024 data. CMS is required to reassess the value of the data collected every 4 years.

postoperative period for a reason related to the original procedure.[21] The CMS-specified global surgeries are minor and major global surgeries that are furnished annually 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.[22] CMS encouraged those practitioners working in practices with fewer than 10 practitioners to report data, if feasible.

Appendix C describes the Federal requirements and guidance referenced in this report.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 110,650 CMS-specified global surgeries provided from January 1 through March 31, 2018 (audit period) with claims that included Medicare payments totaling $78.3 million, for which any practitioners (or practitioners in the same practice) in the reporting States, reported postoperative visits using CPT code 99024 in Medicare Part B claims data.[23, 24, 25] CMS expected to use both required and voluntarily reported data, and thus both were included in this audit.[26] We reviewed only those CMS-specified global surgeries for which the global period did not overlap with the postoperative period of another global surgery for the same patient and practice.[27]

We selected a simple random sample of 105 global surgeries with claims that included Medicare payments totaling $75,744 with reported postoperative visits and requested and reviewed the

[21] The postoperative period within the global period for major surgeries includes the surgery date (after the surgery has been performed) and the 90 days following the surgery date. The postoperative period for minor surgeries is the 10 days following the surgery date.

[22] The Medicare allowed charge is the lower of the actual charge or the fee schedule amount.

[23] Congress mandated that CMS gather a representative sample of information to value global surgical services and that we audit a sample of the data CMS collected. Given the parameters of CMS's data collection, we were able to review only 1.74 percent of the 6,367,774 global surgeries provided nationwide from Jan. 1 through Mar. 31, 2018. CMS limited which global surgeries and which practitioners were required to report, and CMS did not require linking the reported postoperative visits to a global surgery, which further limited the global surgeries that could be covered by our audit.

[24] These were the most current data available at the start of the audit.

[25] A surgery was included in the sampling frame if there was at least one postoperative visit reported, but a practitioner could have provided more postoperative visits that they did not report using CPT code 99024.

[26] Not all practitioners were required to report postoperative visits, and not all patients or global surgeries require postoperative visits.

[27] Because CMS did not require that the reported postoperative visit be linked to a specific global surgery, we could not identify the relevant surgery for the reported postoperative visit if the patient had more than one surgery that could have been associated with the postoperative visit.

medical records to verify the accuracy of the reported information.[28] Using the medical records obtained for 103 of the 105 sampled global surgeries, we determined whether the practitioners accurately reported the postoperative visits provided using CPT code 99024 in the claims data.[29, 30] We sent a survey to those practices whose practitioners did not report all postoperative visits using CPT code 99024 that were documented in the medical records. We also compared the number of postoperative visits documented in the medical records with the number of postoperative visits identified in the Physician Time File that CMS considered in valuing the global surgery fee.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology. Appendix D contains our statistical sampling methodology. Appendix E contains the sample results and estimates.

FINDINGS

Some practitioners in reporting States did not accurately report all postoperative visits to CMS. Also, for most of the global surgery fees covered by this audit, the number of postoperative visits provided during the global period was different from the number of postoperative visits considered in valuing the global surgery fees. Specifically:

[28] For those global surgeries in which the surgery was provided at a facility (hospital or ambulatory surgical center) rather than an office, we also requested medical records from the facility to capture the postoperative visits that could have occurred during the facility stay.

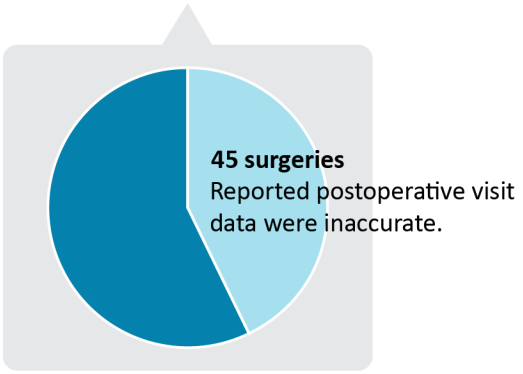
[29] After we selected our sample, we found that two of the selected global surgeries may have included postoperative visits that were associated with facilities under investigation; therefore, we did not obtain medical records for those two global surgeries. For purposes of our estimates, we treated those global surgeries as if the medical record showed that the number of associated postoperative visits did not differ from those reported using CPT code 99024 or from those considered in the valuation of the global surgery fee.

[30] We determined that a postoperative visit was provided when the practitioner furnishing the sampled global surgery (or another practitioner from the same practice) documented a followup visit for the surgery in the patient's medical record and did not receive payment separate from the global fee.

- For 45 of 105 sampled global surgeries, a total of 98 postoperative visits were not accurately reported to CMS.[31] Based on our sample results, we estimated that for 47,421 of the 110,650 global surgeries in our sampling frame, there was a difference of 103,273 postoperative visits between the number of visits reported and the number of visits provided.[32] This occurred because practitioners were unfamiliar with CMS's data collection requirements, or their billing systems were not designed to always submit CPT code 99024 on claims to CMS.

Figure 1: Reporting Results

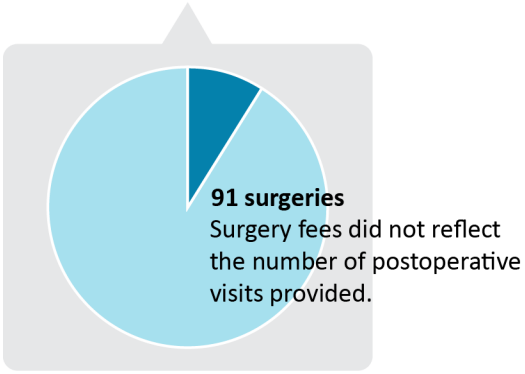
Out of **105** randomly sampled global surgeries



- For 91 of 105 sampled global surgeries, Medicare's global surgery fees did not reflect the number of postoperative visits provided. Although practitioners are not required to provide Medicare patients the number of postoperative visits CMS considers in valuing the global surgery fee, CMS, in valuing the fees for these 91 global surgeries, considered a net 203.5 postoperative visits more than the number of postoperative visits provided by practitioners.[33] Based on our sample results, we estimated that CMS considered a net 214,450 postoperative visits more than the number of postoperative visits provided by practitioners when valuing fees associated with global surgeries. Therefore, we estimated that Medicare paid a net $5.7 million more and

Figure 2: Valuation Results

Out of **105** randomly sampled global surgeries



[31] The 98 postoperative visits that were not accurately reported consisted of 94 unreported postoperative visits that were documented in the patients' medical records and 4 reported postoperative visits that were not supported by the patients' medical records.

[32] The difference of 103,273 postoperative visits consisted of unreported postoperative visits and postoperative visits that were not supported by the patients' medical records.

[33] For each sampled global surgery, we compared the postoperative visits provided (number and dollar value) for each sample item to the postoperative visits considered in valuing the global surgery fee. See Appendix F for the methodology we used to calculate our net sample results (i.e., the difference between the number of postoperative visits considered in valuing the global surgery fee and the number of visits provided, as well as their associated dollar values).

Medicare patients paid a net $1.7 million more than would have been paid if global surgery fees reflected actual utilization of postoperative visits.[34, 35]

CMS explained in the Medicare CY 2017 Physician Fee Schedule Final Rule that it does "not use actual data on services furnished to update the rates."[36] Instead, for updating global surgery fees, CMS relied in part on surveys in which practitioners identified the services needed for the typical patient described in the survey. Considering actual data when updating global surgery fees may improve CMS's valuation of services provided to a typical patient.

SOME POSTOPERATIVE VISITS WERE NOT ACCURATELY REPORTED

Federal Requirements and Guidance

CMS required practitioners in the reporting States who work in practices that include 10 or more practitioners to report CPT code 99024 on claims for postoperative visits of CMS-specified global surgeries.[37, 38] Practitioners were required to document that postoperative visits were provided and that CPT code 99024 was correctly used, such as by a note documenting the visit in the patient's medical record.[39, 40] CMS encouraged practitioners working in practices with fewer than 10 practitioners to report data, if feasible.[41]

[34] See footnote 32 for how positive, negative, or zero differences were calculated for each sampled global surgery. The net estimates throughout this report are statistical estimates based on the positive, negative, and zero differences generated by those calculations.

[35] The actual estimates were $5,723,292 and $1,666,631, respectively.

[36] 81 Fed. Reg. 80170, 80209 (Nov. 15, 2016).

[37] 81 Fed. Reg. 80170, 80222 (Nov. 15, 2016).

[38] According to CMS's "New Claims-Based Reporting Requirements for Post-Operative Visits Guide for Practitioners," issued in June 2017, postoperative visits are defined as followup E/M visits provided during the postoperative period for reasons related to the original procedure.

[39] According to CMS's "Claims-Based Reporting Requirements for Post-Operative Visits Frequently Asked Questions," issued in June 2017, practitioners were required to report CPT code 99024 for all postoperative visits furnished during the global period, regardless of the setting in which the postoperative care was furnished.

[40] According to CMS's "New Claims-Based Reporting Requirements for Post-Operative Visits Guide for Practitioners," issued in June 2017, "As a part of Medicare billing requirements, practitioners must be able to provide documentation to demonstrate post-operative visits were provided and that demonstrates CPT code 99024 was correctly used, such as a note documenting the visit in the patient's medical chart."

[41] New Claims-Based Reporting Requirements for Post-Operative Visits Guide for Practitioners; 81 Fed. Reg. 80170, 80222 (Nov. 15, 2016).

Unreported Major Surgery Postoperative Visits

Of the 105 sampled global surgeries (97 major and 8 minor surgeries), 42 major surgeries had a total of 94 unreported postoperative visits. None of the minor surgeries in our sample had unreported postoperative visits. Of the 94 unreported postoperative visits, 74 occurred during a hospital stay, and 20 occurred in an outpatient or office setting.

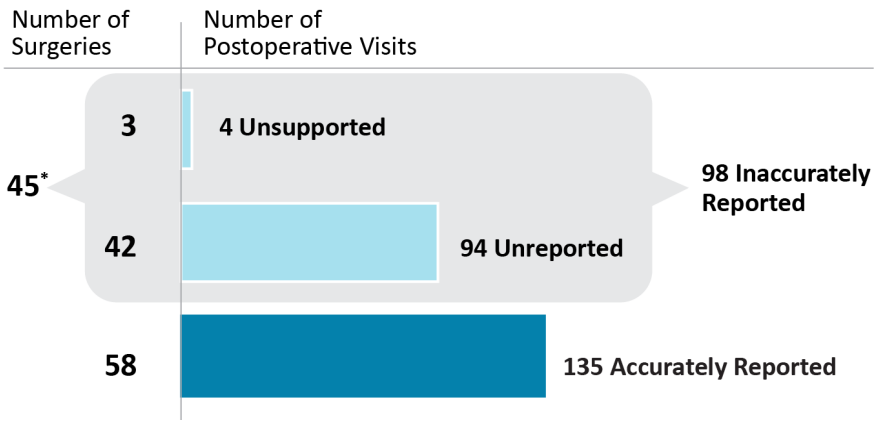
Of the 42 major sampled global surgeries with unreported postoperative visits, 12 major global surgeries were provided by practitioners in practices with fewer than 10 practitioners that voluntarily reported a portion of their postoperative visits. The 12 global surgeries had a total of 33 unreported visits. The remaining 30 major sampled global surgeries had 61 unreported postoperative visits that were provided by practitioners in practices with 10 or more practitioners that were required to report the visits.

Unsupported Postoperative Visits

Almost all the postoperative visits that were reported using CPT code 99024 for the 105 sampled surgeries were supported in the medical records. However, for three global surgeries, we were unable to verify in the medical records that a total of four reported visits were provided.

For two patients with sampled global surgeries, medical records did not support that the practitioners who reported CPT code 99024 for three visits on the associated claims were involved with the services provided. CMS agreed that these did not qualify as postoperative visits for the data collection policy and should not have been reported using CPT code 99024. The remaining visit—for the third sampled global surgery—was reported on the surgery date; however, the medical record on that date supported only the surgery, not a postoperative visit.

Figure 3: Postoperative Visit Reporting for 103 Sampled Global Surgeries



* There were 102 accurately reported postoperative visits for these 45 surgeries.

Effect of Postoperative Visits That Were Not Accurately Reported

Based on our sample results, we estimated that for 47,421 global surgeries in our sampling frame, there was a difference of 103,273 postoperative visits between the number of postoperative visits reported and the number of visits provided.[42] Specifically, we estimated that 44,260 global surgeries had 99,058 unreported postoperative visits that were supported by the associated patients' medical records, and 3,161 global surgeries had 4,215 reported postoperative visits that were not supported by the associated patients' medical records.[43]

Practitioners Were Unaware of the Global Surgery Policy or Did Not Have Billing Systems Capable of Meeting CMS Data Collection Policy

Based on responses to our survey, we found that these errors occurred because some practitioners and the practices' staff were either unaware that certain practitioners were required to report their postoperative visits to CMS, or they did not understand which visits were considered postoperative visits under Medicare's global surgery policy.

Many practices used CPT code 99024 as an internal code to track no-charge visits occurring during the global period. After CMS implemented its data collection policy, visits with CPT code 99024 were to be submitted as claims to Medicare. However, practice staff did not stop using CPT code 99024 to internally track no-charge visits after CMS implemented the data collection policy, which may have led to incorrect reporting. In addition, not all staff may have been aware of CMS's data collection policy and therefore did not always submit claims using CPT code 99024, resulting in unreported postoperative visits.

Further, not all practices' billing systems were adequate to meet the CMS data collection policy. Specifically, some systems were not designed to always properly submit CPT code 99024. These systems may not have submitted claims using CPT code 99024 to Medicare because the claims did not have associated charges. Further, some practices' billing staff did not have access to the medical records necessary to bill Medicare using CPT code 99024. The practices that bill on behalf of practitioners tended to have records of the postoperative visits that occurred at the practices' locations only. Unless the practitioner was part of a hospital's medical group, the practice's billing staff typically did not have access to the medical records that would document postoperative visits during a hospital stay and would therefore not have the information necessary to submit claims using CPT code 99024.

[42] For purposes of our estimates, we treated those global surgeries that were associated with facilities under investigation as if the medical record showed that the number of associated postoperative visits did not differ from those reported using CPT code 99024 or from those considered in the valuation of the global surgery fee.

[43] The 90-percent confidence interval for the number of global surgeries in the sampling frame with unsupported postoperative visits was 868 to 7,985. The 90-percent confidence interval for the number of unsupported postoperative visits for global surgeries in the sampling frame was 1,306 to 10,136.

CMS expected practitioners to be aware of the data collection policy because it was published in the *Federal Register* and because CMS posted policy information and other guidance online and set up nationwide calls to discuss the policy. CMS's guidance did not explain how postoperative visits should be documented in medical records other than that they be noted. CMS also did not directly contact practitioners regarding the policy or the nationwide calls. As a result, practitioners that were not actively reviewing information published in the *Federal Register* or on CMS's website may not have been aware of the data collection policy and its requirements.

Although CMS staff stated that CMS continuously communicates with MACs, CMS did not provide any documentation to support that the data collection policy was part of that communication, and according to the MACs, they did not have discussions or correspondence with CMS about the data collection policy. The MACs could have provided practitioners with information on the data collection policy on their websites and through other communication methods. The MACs had billing edits that rejected claims for E/M visits during the global period when they were submitted without a modifier indicating that the claim could be paid separately. CMS could have requested that the MACs make updates or provide further guidance about billing CPT code 99024.

MOST GLOBAL SURGERY FEES DID NOT REFLECT THE NUMBER OF POSTOPERATIVE VISITS PROVIDED

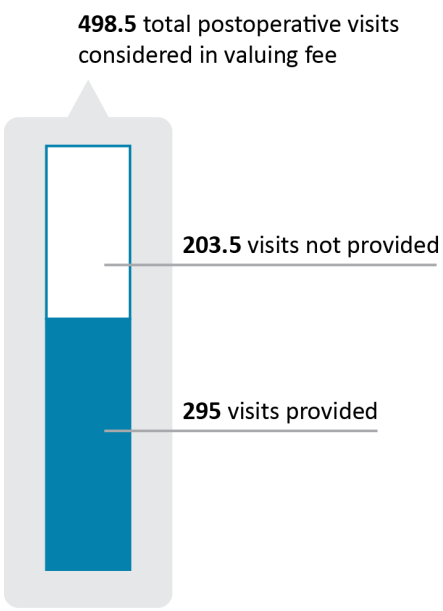
Federal Requirements

Chapter 12, section 40, of the *Medicare Claims Processing Manual* provides that each global surgery fee include payment for the postoperative visits provided during the global period when provided by the practitioner furnishing the surgery and other practitioners in the same group practice. These practitioners may not bill and receive separate payment for postoperative visits related to the surgery in the global period. The global surgery fee compensates practitioners for related E/M postoperative visits considered by CMS in valuing each global surgery regardless of whether the visits are actually provided. Practitioners are not required to provide Medicare patients the number of postoperative visits CMS considered in valuing the global surgery fee.

The Number of Postoperative Visits Considered in Valuing the Global Surgery Fee Differed From the Number of Visits Provided

We found that for 91 sampled global surgeries, the number of postoperative visits provided was different from the number of postoperative visits CMS considered in valuing the global surgery. For example, for the 9 knee replacement surgeries in our sample, CMS considered 7 postoperative visits for each when valuing the associated global surgery fee, or 63 total postoperative visits for the 9 surgeries, but practitioners provided only a total of 46 postoperative visits for the surgeries.[44] CMS, in valuing these 91 global surgery fees, considered a total of 498.5 postoperative visits, but practitioners provided a total of 295 postoperative visits for the 91 surgeries, a difference of a net 203.5 postoperative visits.[45] For the 91 global surgeries, Medicare paid a net $5,431 and Medicare patients paid a net $1,582 more than would have been paid if global surgery fees reflected actual utilization of postoperative visits.

Figure 4: Valuation for 91 Sampled Global Surgeries



Effect of the Number of Postoperative Visits Provided Differing From the Number CMS Used in Valuing the Global Surgery Fees

Based on our sample results, we estimated that CMS, in valuing fees associated with global surgeries in our sampling frame, considered a net 214,450 postoperative visits more than the number of postoperative visits provided by practitioners. For global surgeries included in our sampling frame, we estimated that Medicare paid a net $5.7 million and Medicare patients paid a net $1.7 million more than would have been paid if global surgery fees reflected actual utilization of postoperative visits.

[44] For the 9 knee replacement surgeries, the number of postoperative visits provided per surgery ranged from 3 to 11 visits, with 7 visits provided for only 1 surgery. Of the 8 remaining global surgeries, there were 21 more postoperative visits considered in valuing the global surgery fee than provided for 7 global surgeries and 4 fewer postoperative visits considered in valuing the global surgery fee than provided for 1 global surgery, for a net difference of 17 visits.

[45] There were 225.5 more postoperative visits considered in valuing the global surgery fee than provided for 81 global surgeries and 22 fewer postoperative visits considered in valuing the global surgery fee than provided for 10 global surgeries.

Differences Occurred Because CMS Did Not Use Actual Data in Valuing CMS-Specified Global Surgery Fees

CMS explained in the Medicare CY 2017 Physician Fee Schedule Final Rule that it does "not use actual data on services furnished to update the rates."[46] Instead, for updating global surgery fees, CMS relied in part on surveys in which practitioners identified the services needed for the typical patient described in the survey. CMS did not have access to data on the number of visits furnished when updating the fees because CMS did not begin requiring practitioners to report postoperative visits for global surgeries until July 2017. Considering actual data when updating global surgery fees may improve CMS's valuation of services provided to a typical patient. We looked at CMS revaluations before, during, and after the audit period and found that the number of visits considered in valuing the CMS-specified global surgery fees differed from the number provided because CMS infrequently made changes to the number of postoperative visits it considered. From 2014 through 2023, for the 293 CMS-specified global surgeries in the Physician Time File, CMS made changes to the number of postoperative visits considered for only 51 global surgeries.[47, 48]

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- educate practitioners and encourage the practitioners to educate the practices' staff on its data collection policy requirements for inpatient and outpatient settings and direct the MACs to educate individual practitioners on reporting requirements for postoperative visits after global surgeries;

- establish detailed requirements for documenting postoperative visits provided in all settings in the medical records;

- take one of the following steps to improve reporting of postoperative visits: (1) establish and maintain a mechanism to identify practitioners that are required to report their postoperative visits and notify them of the reporting requirement, (2) require all practitioners to report postoperative visits, or (3) revise its requirements to clarify which practitioners are required to report;

[46] 81 Fed. Reg. 80170, 80209 (Nov. 15, 2016).

[47] To make this determination, we reviewed the changes CMS made to the number of postoperative visits for each CMS-specified global surgery CPT code in the Physician Time File over the past 10 years.

[48] Of these 51 global surgeries, the most recent changes to the number of postoperative visits were effective before 2018 for 23 global surgeries, in 2018 for 6 global surgeries, and after 2018 for 22 global surgeries. CMS changes for 3 of the 51 global surgeries were related only to the level of the postoperative visits and not the total number of postoperative visits.

- improve its methodology for data collection to identify the relevant global surgery on postoperative visit claims and to obtain data on Medicare postoperative visits during hospital stays; and

- update its valuation of the global surgery fees to reflect the number of postoperative visits actually being provided to Medicare patients, which could have reduced payments for the global surgeries in our sampling frame by an estimated $5,723,292 for Medicare and an estimated $1,666,631 for Medicare patients.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our recommendations, CMS concurred with our first recommendation but did not indicate either concurrence or nonconcurrence with our remaining four recommendations. In addition, it detailed steps it has taken and plans to take in response to our recommendations.

CMS also provided separate technical comments that we addressed as appropriate. CMS's comments, excluding technical comments, are included as Appendix G.

After reviewing CMS's comments, we maintain that our recommendations are valid. The following sections summarize CMS's comments and our response.

CMS COMMENTS

- Regarding our first recommendation that CMS educate practitioners on its data collection policy requirements and direct the MACs to educate individual practitioners on postoperative visits reporting requirements, CMS stated that it has conducted extensive national education on global surgery postoperative visit reporting requirements and would conduct additional education on data collection policy requirements. Also, CMS stated that it will direct the MACs to educate individual practitioners on reporting requirements for postoperative visits after global surgeries, as needed.

- Regarding our second recommendation to establish detailed requirements for documenting postoperative visits provided, CMS stated that it has published guidance clarifying requirements for documenting postoperative visits, but it would review this guidance to consider whether additional detail should be added.

- Regarding our third recommendation to improve reporting of postoperative visits, CMS stated that it continues to implement MACRA requirements by requiring use of a

modifier as well as an add-on code.[49] According to CMS, these new requirements would more appropriately reflect the time and resources involved with global surgeries and postoperative visits; however, the new requirements apply only to practitioners who are not providing both the surgery and the postoperative services. CMS did not indicate how these new reporting requirements addressed our recommended steps for improvements. CMS stated that it would consider making additional changes as suggested by our recommendation.

- Regarding our fourth recommendation that CMS improve its data collection methodology, CMS stated that it would consider whether changes can be made to increase reporting of Medicare postoperative visits during hospital stays. CMS did not address the part of the recommendation regarding improving its methodology for data collection to identify the relevant global surgery on postoperative visit claims.

- Regarding our fifth recommendation that CMS update its valuation of the global surgery fees to reflect the number of postoperative visits actually being provided to Medicare patients, CMS stated that it continued to collect data on the number and level of postoperative visits to assess the accuracy of global surgery valuation. CMS also stated that this process would take time as there are more than 4,000 global surgery codes. CMS explained it was committed to collecting appropriate data to inform potential changes to the valuation of global surgery fees.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing CMS's comments, we maintain that our recommendations are valid. For the second recommendation, we maintain that all practitioners should document their postoperative visits for Medicare global surgeries so there is no ambiguity on whether a postoperative visit was provided. For example, in guidance published in June 2017, CMS referred to a note as acceptable documentation for the postoperative visit.[50] However, we think CMS should update this published guidance to clarify the requirements for what is essential to be included in the practitioner's notes for documenting postoperative visits. This would not only benefit continued patient care but also better identify a postoperative visit in the documentation needed to improve the accuracy of valuing global surgeries.

[49] Starting in CY 2025, CMS requires practitioners to use a modifier when billing any 90-day global surgical package if the practitioner expects to furnish only the surgical procedure portion of the global package, but no postoperative visits (89 Fed. Reg. 97710, 97961-97971 (Dec. 9, 2024)). CMS also finalized a new add-on code for CY 2025 for postoperative care services furnished by a practitioner other than the one who performed the surgical procedure.

[50] According to CMS's "New Claims-Based Reporting Requirements for Post-Operative Visits Guide for Practitioners," issued in June 2017, "As a part of Medicare billing requirements, practitioners must be able to provide documentation to demonstrate post-operative visits were provided and that demonstrates CPT code 99024 was correctly used, such as a note documenting the visit in the patient's medical chart."

For the third and fourth recommendations, we maintain that CMS should address the reporting issues identified in this report by improving its data collection methodology for global surgery postoperative visit claims.

For the fifth recommendation, we maintain that CMS should improve its procedures for valuation of the global surgery fees to reflect the number of postoperative visits provided to Medicare patients. We acknowledge that CMS continues to collect data on the number and level of postoperative visits to assess the accuracy of global surgery valuation and that this process will take time. Once CMS improves its data collection methodology and receives more accurate data, CMS should use the data in the valuation of global surgery fees so the fees will reflect the number of postoperative visits actually being provided to Medicare patients.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 110,650 CMS-specified global surgeries provided to Medicare patients from January 1 through March 31, 2018 (audit period) with claims that included Medicare payments totaling $78,327,173, for which practitioners (or practitioners in the same practice) in the reporting States reported postoperative visits using CPT[51] code 99024 in Medicare Part B claims data.[52]

Specifically, we reviewed CMS-specified global surgeries for which the global period did not overlap with the postoperative period of other major and minor global surgeries provided by the same practice for the same patient. CMS did not require that the reported postoperative visit be linked to a specific global surgery; therefore, when the patient had more than one surgery that could have been associated with the postoperative visit, we could not identify the surgery related to the reported postoperative visit. Note that our audit did not cover global surgeries for which no postoperative visits were reported.

From the 110,650 CMS-specified global surgeries, we selected a simple random sample of 105 global surgeries with claims that included Medicare payments totaling $75,744.

We did not perform an overall assessment of the internal control structures of CMS. Rather, we limited our review to those controls that were significant to our objective. Specifically, our review of internal controls focused on the control activities for processing and reviewing Medicare claims for postoperative visits. We assessed whether CMS and the Part B MACs designed their information systems, including system edits, and control activities to achieve objectives and respond to risks. We reviewed CMS's requirements and guidance provided to the practitioners in the nine reporting States and the Part B MACs processing the claims for those nine States. We also identified CMS's control activities regarding policies and procedures for managing contracts and developing physician fees as well as CMS's related review processes.

To assess the reliability of the data obtained from CMS's National Claims History File, we removed duplicate claims and ensured that the patient, surgery CPT code, and surgery date represented unique surgeries. We confirmed that all dates of service of claims associated with global surgeries in the sampling frame were within our scope. We determined that the data were sufficiently reliable for the purposes of this report.

We conducted our audit from August 2020 through February 2025.

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[52] These were the most current data available at the start of the audit.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal laws, regulations, and guidance;
- discussed Medicare's global surgery policy and procedures, including the reporting of postoperative visits and how they were valued in global surgery fees, with CMS staff;
- discussed claim processing of postoperative visits and other E/M visits within the postoperative period with staff from Part B MACs responsible for processing claims in the reporting States;
- obtained from the National Claims History file the Medicare Part B claims for major and minor global surgery CPT codes and CPT code 99024 from October 3, 2017, through June 29, 2018;[53]
- identified a sampling frame of 110,650 CMS-specified global surgeries provided from January 1 through March 31, 2018;
- selected for review a simple random sample of 105 global surgeries;
- obtained from the National Claims History file the Medicare claim activity for services provided within 100 days of the sampled global surgery date for the patients associated with the global surgeries in our sample;
- identified for each sampled global surgery:
    - the name of the patient,
    - date of the surgery,
    - postoperative period,
    - name of the practitioner who provided the surgery and the billing practice, and
    - the name of the facility where the surgery took place;
- requested and received medical records for 103 of the 105 global surgeries and their postoperative visits from the billing practice and the facility where the surgery took place (see footnote 29);

[53] To ensure that we did not select global surgeries when other global surgeries were provided during the global period, we needed to obtain claims 90 days before and after the scope of our audit.

- for each of the 103 global surgeries:

    - reviewed those medical records and identified the postoperative visits provided and compensated by the global surgery fee;

    - reviewed the Medicare claim activity and identified postoperative visits reported using CPT code 99024;

    - reviewed CMS's Physician Time File and identified the E/M visit CPT codes and total number of postoperative visits that CMS considered when valuing the global surgery fee for each sampled global surgery;

    - determined whether the postoperative visits reported using CPT code 99024 were supported by the medical records;

    - determined the difference, if any, between the number of postoperative visits provided to the patient based on medical record documentation and the number of postoperative visits reported using CPT code 99024;

    - sent a survey to those practices that we found did not report all postoperative visits documented in the medical records using CPT code 99024;

- used the sample results to estimate the number of surgeries and postoperative visits that were unsupported, unreported, and inaccurately reported in the sampling frame;

- for each global surgery in the sample, determined the difference, if any, between the number of postoperative visits provided to the patient based on medical record documentation and the number of postoperative E/M visits considered by CMS in valuing the global surgery fee and determined the dollar value of the difference;

- used the sample results to estimate the net difference in the sampling frame between the number of postoperative visits provided and the number of postoperative E/M visits considered by CMS in valuing the global surgery fee;

- used the sample results to estimate the net values of Medicare payment and Medicare patient payment for E/M visits that were considered by CMS in valuing the global surgery fees in our sampling frame but not provided to patients during global periods in our audit period; and

- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided	A-05-09-00054	5/1/2012
Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided	A-05-09-00053	5/1/2012
Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005	A-05-07-00077	4/20/2009

APPENDIX C: FEDERAL REQUIREMENTS AND GUIDANCE

FEDERAL REQUIREMENTS

Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), P.L. No. 114-10 (Apr. 16, 2015), amended the Social Security Act by adding section 1848(c)(8), which prohibited CMS from implementing an imminent policy that would have required the transition of all 10-day and 90-day global surgery packages to 0-day global periods. Rather, it required CMS to collect data on services included in global surgical packages. Specifically, section 1848(c)(8)(B)(i) of the Act states:

> Subject to clause (ii), the Secretary shall through rulemaking develop and implement a process to gather, from a representative sample of physicians, beginning not later than January 1, 2017, information needed to value surgical services. Such information shall include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period, as appropriate. Such information shall be reported on claims at the end of the global period or in another manner specified by the Secretary.

Section 1848(c)(8)(B)(iii) states:

> The Inspector General of the Department of Health and Human Services shall audit a sample of the information reported under clause (i) to verify the accuracy of the information so reported.

Section 1848(c)(8)(C) states:

> For years beginning with 2019, the Secretary shall use the information reported under subparagraph (B)(i) as appropriate and other available data for the purpose of improving the accuracy of valuation of surgical services under the physician fee schedule under this section.

In the Medicare CY 2017 Physician Fee Schedule Final Rule (81 Fed. Reg. 80170, 80212–80225 (Nov. 15, 2016)), CMS finalized the requirement to report postoperative visits furnished during 10- and 90-day global periods using CPT[54] code 99024 for surgeries provided on or after July 1, 2017. CMS did not require time units or modifiers to distinguish levels of visits to be reported. Since CPT code 99024 is specifically limited to postoperative care, CMS required reporting of postoperative visits only. CMS required practitioners to report postoperative visits if they: (1) practice in one of the following 9 States: Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, or Rhode Island; (2) practice in a group of 10 or more practitioners; and (3) provide global services under one of the procedure codes of surgeries furnished annually by more than 100 practitioners and are either furnished more than 10,000

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times or have allowed charges of more than $10 million annually. Teaching physicians were subject to the same reporting requirements and were to use the GC or GE modifier as appropriate.[55]

FEDERAL GUIDANCE

In June 2017, CMS responded to frequently asked questions regarding the data collection requirements.[56] It explained that reporting of CPT code 99024 is required for all postoperative visits furnished during the global period, regardless of the setting in which the postoperative care is furnished, including inpatient hospital visits. Postoperative visits covered by the global period must be reported if they would otherwise be separately reportable if not for the global period. CPT code 99024 should be reported only once if furnishing multiple postoperative visits to the same patient on the same day. Postoperative visits should be reported with CPT code 99024 when the visit is furnished on the same day as an unrelated E/M service. CPT code 99024 should be reported only for postoperative visits that are not otherwise billed because it is included in the global period.

CMS also issued a guide for practitioners regarding the reporting requirements.[57] It instructed that postoperative visits are reported through the usual process for filing claims. The claim includes information about the practitioner, date of service, and the units of service. It explained that practitioners are not required to report additional data to link postoperative visits to a particular procedure. Finally, it stated that, as a part of Medicare billing requirements, practitioners must be able to provide documentation to demonstrate that postoperative visits were provided and that CPT code 99024 was correctly used, such as a note documenting the visit in the patient's medical record.

[55] The GC and GE modifiers are added for services performed in part by a resident under the direction of a teaching physician and for services performed by a resident without the presence of a teaching physician under the primary care exception, respectively.

[56] See CMS, "Claims-Based Reporting Requirements for Post-Operative Visits Frequently Asked Questions," issued in June 2017.

[57] See CMS, "New Claims-Based Reporting Requirements for Post-Operative Visits Guide for Practitioners," issued in June 2017.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 110,650 CMS-specified global surgeries provided to Medicare patients with dates of service from January 1 through March 31, 2018, with claims that included Medicare payments totaling $78,327,173. The global surgeries in the sampling frame were provided by practitioners in nine reporting States (footnotes 5 and 6) for which practitioners (or practitioners in the same practice) reported postoperative visits using CPT[58] code 99024 and for which the global period did not overlap with the postoperative period of other major and minor global surgeries provided by the same practice for the same patient. In addition, the global surgeries in the sampling frame were associated with practices and practitioners with active NPIs who were not under investigation by OIG's Office of Investigations (footnote 28).

SAMPLE UNIT

The sample unit was a global surgery.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 105 global surgeries.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the items in the sampling frame. After generating 105 random numbers, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to estimate (for the sampling frame): (1) the number of surgeries with unsupported, unreported, and inaccurately reported postoperative visits; (2) the number of postoperative visits unsupported, unreported, and inaccurately reported;

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(3) the net difference between the number of postoperative visits provided and the number of postoperative visits considered in valuing the global surgery fee; and (4) the net values of Medicare payment and Medicare patient payment for postoperative visits that were considered in valuing the global surgery fees but not provided. We used the OIG, OAS, statistical software to calculate the point estimates and the corresponding lower and upper limits of the two-sided, 90-percent confidence intervals (Appendix E, Tables 4 through 6).

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

SAMPLE DETAILS AND RESULTS

Table 1: Sample Details

Sampling Frame		Random Sample	
Number of Global Surgeries	**Medicare Payments for Global Surgeries**	**Number of Global Surgeries**	**Medicare Payments for Global Surgeries**
110,650	$78,327,173	105	$75,744

Table 2: Sample Results for Global Surgeries With Inaccurately Reported Postoperative Visits

Type of Finding	Sampled Global Surgeries With Finding	Postoperative Visits for Sampled Global Surgeries With Finding
Inaccurately reported visits	45	98
Unreported visits	42	94
Unsupported visits	3	4

Table 3: Sample Results for Differences Between the Number of Postoperative Visits Considered in Valuing the Fee and the Number of Visits Provided

Sampled global surgeries with differences	91
Net difference in number of postoperative visits	203.5
Associated net dollar value of Medicare payments	$5,431
Associated net dollar value of Medicare patient payments	$1,582

ESTIMATES

Table 4: Estimated Number of Global Surgeries in the Sampling Frame With Inaccurately Reported Postoperative Visits
(Limits Calculated at the 90-Percent Confidence Level)

	Estimated Number of Global Surgeries		
Estimates	**Inaccurately Reported Postoperative Visits**	**Unreported Postoperative Visits**	**Unsupported Postoperative Visits**
Point estimate	47,421	44,260	3,161
Lower limit	38,367	35,361	868
Upper limit	56,817	53,638	7,985

Table 5: Estimated Number of Postoperative Visits Inaccurately Reported for Global Surgeries in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)

	Estimated Number of Postoperative Visits		
Estimates	**Inaccurately Reported Postoperative Visits**	**Unreported Postoperative Visits**	**Unsupported Postoperative Visits**
Point estimate	103,273	99,058	4,215
Lower limit	79,779	75,596	1,306
Upper limit	132,293	128,265	10,136

Table 6: Estimated Difference in the Sampling Frame Between the Number of Postoperative Visits Considered in Valuing the Fee for Global Surgeries and the Number of Visits Provided
(Limits Calculated at the 90-Percent Confidence Level)

		Associated Net Dollar Value	
Estimates	**Net Difference in Number of Postoperative Visits Considered and Provided**	**Medicare Payments**	**Medicare Patient Payments**
Point estimate	214,450	$5,723,292	$1,666,631
Lower limit	173,280	$4,435,418	$1,320,708
Upper limit	255,678	$6,915,535	$1,990,232

APPENDIX F: STEPS FOR CALCULATING DIFFERENCES BETWEEN THE NUMBER OF POSTOPERATIVE VISITS CONSIDERED IN VALUING THE GLOBAL SURGERY FEE AND THE NUMBER OF VISITS PROVIDED, AS WELL AS THEIR ASSOCIATED DOLLAR VALUES

1) **E/M visits considered in valuing the global surgery fee:** We identified the number of E/M visit CPT[59] codes considered in valuing the global surgery fee for each sampled global surgery CPT code from the Physician Time File. For example, a knee replacement surgery (CPT code 27447) has a total of 7 E/M visits considered in valuing its fee.

Table 7: Number and Type of E/M Visit CPT Codes in the Physician Time File for CPT Code 27447

Surgery CPT Code	CPT Code 99213 Office Visit	CPT Code 99231 Hospital Care	CPT Code 99232 Hospital Care	CPT Code 99238 Hospital Discharge
27447	3	1	2	1

2) **Fees for E/M visits:** We determined the Physician Fee Schedule amounts using the same pricing information as the sampled surgery since the pricing of physician services changes depending on where they were performed. The pricing information includes the MAC number, locality code, and fee type (facility or nonfacility depending on place of service). For example, if the knee replacement surgery was performed at a facility in Ohio, we looked to see what the fee would be for each E/M visit considered in valuing the global surgery fee if performed at a facility in Ohio.

Table 8: Physician Fee Schedule Amounts for E/M Visit CPT Codes at Ohio Facility

MAC Number	Locality Code	Fee Type	CPT Code 99213 Office Visit	CPT Code 99231 Hospital Care	CPT Code 99232 Hospital Care	CPT Code 99238 Hospital Discharge
Ohio MAC Number	Ohio Locality Code	Facility	$50.99	$39.10	$72.47	$72.44

3) **Lowest E/M visit fee:** We identified the lowest E/M visit fee for each sampled surgery. For the Ohio knee replacement surgery example, the lowest E/M visit fee would be $39.10.

4) **E/M visit allowed charge:** We identified the allowed charge of the lowest E/M visit fee applicable to one E/M visit. If any adjustments were made to the global surgery fee, we applied the same proportion of adjustments to the lowest E/M visit fee for each sampled

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surgery to calculate the allowed charge for one E/M visit.[60, 61] Only 11 of the 105 sampled global surgeries had at least 1 of these adjustments. There were no payment adjustments to the fee for the Ohio knee replacement surgery in our example, so we used $39.10 as the allowed charge of the lowest E/M visit fee applicable to one E/M visit.

5) **Patient and Medicare paid proportions:** We identified the proportion of the allowed charge that the patient and Medicare paid for each sampled global surgery. The proportions varied because insurance beyond Medicare could have covered some of the payment, the patient may have needed to pay a deductible, and Medicare had adjustments that modified the amount it paid of the allowed charge.[62] For our example, the allowed charge for an Ohio knee replacement surgery is $1,365.97. The patient had no deductible, so they paid only the 20-percent coinsurance of $273.19. The remaining 80 percent ($1,092.78) was reduced by 2 percent for sequestration ($21.86), and Medicare paid the practitioner $1,070.92.

Table 9: Example of Patient and Medicare Paid Proportion Determination

(A) Allowed Charge	**(B) Patient Payment** (Deductible + Coinsurance)	**(C) Patient Paid Proportion** [(B) / (A)]	**(D) Sequestration** [(A) – (B) x 2%]	**(E) Medicare Payment to Practitioner** [(A) – (B) – (D)]	**(F) Medicare Paid Proportion** [(E) / (A)]
$1,365.97	$273.19	0.2000	$21.86	$1,070.92	0.7840

6) **Postoperative visit difference:** We subtracted the number of postoperative visits provided as reflected in the medical records from the number of postoperative visits considered by CMS in valuing the global surgery fee to determine the difference. Table 10 includes our findings for three of the knee replacement global surgeries in our sample.

[60] There could have been two relevant adjustments: the Physician Quality Reporting System (PQRS) negative payment adjustment for failing to satisfactorily report data on quality measures and a negative payment adjustment for those who did not demonstrate meaningful use of electronic health records.

[61] For example, if a PQRS negative payment adjustment of 2 percent was applied to the surgery fee schedule amount, the allowed charge was only 98 percent of the surgery fee. We applied the same proportion of 98 percent to the lowest E/M visit fee to calculate the allowed charge for the E/M visit. If this occurred with the Ohio knee replacement example, we would use 98 percent of $39.10, which is $38.32, as the allowed charge for one E/M visit.

[62] Based on the quality of care furnished, Medicare may adjust its payment positively or negatively. This impacted 7 of the 105 sampled global surgeries. In addition, 103 of the 105 sampled global surgeries had sequestration adjustments that reduced Medicare's payment by 2 percent. The two remaining sampled global surgeries did not have sequestration applied because Medicare was not the primary payer and did not pay any of the allowed charge; therefore, the Medicare paid proportion was 0 for these two sampled global surgeries.

Table 10: Examples of Calculating Differences Between the Number of Postoperative Visits Considered in Valuing the Global Surgery Fee and the Number of Visits Provided

	Fewer Visits Provided	More Visits Provided	Same Visits Provided
(A) Postoperative visits considered by CMS in valuing global surgery fee	7	7	7
(B) Postoperative visits provided as reflected in the medical records	5	11	7
(C) Difference in postoperative visits [(A)–(B)]	2	(4)	0

Depending on the number of postoperative visits provided, these calculations resulted in a positive, negative, or zero difference for each sampled global surgery.

7) **Visit difference value:** We multiplied the postoperative visit difference determined in step 6 by the allowed charge of the lowest E/M visit fee applicable to one E/M visit determined in step 4. To provide a conservative estimate of the visit difference value, we used the lowest E/M visit fee for each sampled surgery. To approximate the Medicare and patient paid shares of the dollar-value difference, we used the same proportion that Medicare and the patient paid of the allowed charge of each sampled global surgery determined in step 5 and applied them to the dollar value of the difference in postoperative visits for each sampled global surgery.

Table 11: Examples of Calculating the Medicare Paid and Patient Paid Shares of the Dollar-Value Differences for the Differences in Postoperative Visits

	Fewer Visits Provided	More Visits Provided	Same Visits Provided
(A) Difference in postoperative visits	2	(4)	0
(B) Lowest E/M visit allowed charge	$39.10	$39.10	$39.10
(C) Dollar value of difference [(A) x (B)]	$78.20	($156.40)	$0
(D) Medicare proportion	0.7840	0.7840	0.7840
(E) Medicare paid share of dollar-value difference [(C) x (D)]	$61.31	($122.62)	$0
(F) Patient proportion	0.2000	0.2000	0.2000
(G) Patient paid share of dollar-value difference [(C) x (F)]	$15.64	($31.28)	$0

For each sampled global surgery throughout this report, we made similar calculations for associated dollar-value differences paid by Medicare and Medicare patients. These calculations resulted in a positive, negative, or zero difference for each sampled global surgery.

APPENDIX G: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: March 19, 2025

TO: Megan Tinker
Chief of Staff

FROM: Stephanie Carlton
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries, (A-05-20-00021)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to ensuring that global surgery payments accurately reflect the resources involved in providing care.

Medicare payment for most surgical procedures covers both the procedure and postoperative visits occurring within a global period of either 10 or 90 days following the procedure. Section 1848(c)(8)(B) of the Social Security Act, as added by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), requires CMS to collect data to use in valuing global surgical services. Specifically, CMS is required to collect data on the number and level of postoperative medical visits and other items and services furnished during the global period, as appropriate, to enable CMS to assess the accuracy of global surgical package valuation. To help inform accurate valuation of procedures with global periods, CMS required select practitioners from nine states to report on their postoperative visits (using CPT code 99024) beginning July 1, 2017, for specified high volume or high-cost procedures as specified in 81 FR 80212. CMS analyzed the initial results of this data collection using calendar year 2019 data and compared the results with the expected number of postoperative visits in the physician time file (i.e., the number of visits used in the initial valuation). CMS found that revaluing procedures with 10- and 90-day global periods based on the actual number of postoperative visits reported during the data collection period versus the initial valuation would cause significant shifts in payment for specialties across the Medicare Physician Fee Schedule. Given the magnitude of the potential payment impacts based on our initial review, CMS is continuing to collect and analyze the reported data, while taking additional steps to improve its accuracy for adjusting global surgery payments.

In continuing to improve data collection to implement these MACRA requirements, in the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (PFS) final rule, CMS requires practitioners to use a modifier when billing any 90-day global surgical package if the practitioner expects to furnish only the surgical procedure portion of the global package, but no postoperative visits.[1] The goal of this policy is to improve payment accuracy for these 90-day global package services and is expected to inform CMS about how global package services are typically furnished. For CY 2025, CMS also finalized a new add-on code for postoperative care services furnished by a practitioner other than the one who performed the surgical procedure (or another practitioner in the same group practice). This add-on code will more appropriately reflect the

[1] CY2025 PFS final rule, 89 FR 97961 through 97971.

time and resources involved in these postoperative follow-up visits by practitioners who were not involved in furnishing the surgical procedure.

To help healthcare providers understand the global surgery reporting requirements, CMS has published frequently asked questions and provider education, as well as the CMS list of Global Codes for which reporting on postoperative visits is required. This list is updated and published annually.[2] In addition, since 2018, CMS has issued more than 20 Medicare Learning Network educational products and messages to educate providers about payment policy on global surgery packages and proper coding practices.

CMS looks forward to continuing to improve data collection in accordance with MACRA to ensure accuracy of global surgery payments.

OIG's recommendations and CMS' responses are below.

OIG Recommendation
CMS should educate practitioners and encourage the practitioners to educate the practices' staff on its data collection policy requirements for inpatient and outpatient settings and direct the MACs to educate individual practitioners on reporting requirements for postoperative visits after global surgeries.

CMS Response
CMS concurs with this recommendation. CMS has conducted extensive national education on this topic since 2018, issuing nine Medicare Learning Network publications and 15 messages educating healthcare providers about global surgery package payment and codes required for postoperative visits. CMS will conduct additional education on data collection policy requirements for inpatient and outpatient settings and will direct the MACs to educate individual practitioners on reporting requirements for postoperative visits after global surgeries, as needed.

OIG Recommendation
CMS should establish detailed requirements for documenting postoperative visits provided in all settings in the medical records.

CMS Response
While CMS has published guidance clarifying requirements for documenting postoperative visits, we will review this guidance to consider whether additional detail should be added to clarify requirements for documenting the postoperative visits in the medical records specifically.

OIG Recommendation
CMS should take one of the following steps to improve reporting of postoperative visits: (1) establish and maintain a mechanism to identify practitioners that are required to report their postoperative visits and notify them of the reporting requirement, (2) require all practitioners to report postoperative visits, or (3) revise its requirements to clarify which practitioners are required to report.

CMS Response
As stated above, MACRA mandated that CMS collect data on the number and level of postoperative visits to enable CMS to assess the accuracy of global surgical package valuation.

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[2] https://www.cms.gov/files/document/faq-strategies-improving-global-surgery-payment-accuracy.pdf; https://www.cms.gov/medicare/payment/fee-schedules/physician/global-surgery-data-collection

CMS is continuing to implement these MACRA requirements as described above by requiring the use of a modifier for 90-day global packages in cases where a practitioner expects to furnish only the surgical procedure portion of the global package and does not intend to conduct the postoperative visits themselves, as well as a new add-on code for postoperative care services furnished by a practitioner other than the one who performed the surgical procedure (or another practitioner in the same group practice). These requirements will more appropriately reflect the time and resources involved in these global packages and postoperative follow-up visits. As CMS continues the process of analyzing data collected on postoperative visits, we will consider making additional changes as suggested by OIG in this recommendation.

OIG Recommendation

CMS should improve its methodology for data collection to identify the relevant global surgery on postoperative visit claims and to obtain data on Medicare postoperative visits during hospital stays.

CMS Response

CMS continues to implement the MACRA requirements as described above. CMS will consider whether changes can be made to increase reporting of Medicare postoperative visits during hospital stays.

OIG Recommendation

CMS should update its valuation of the global surgery fees to reflect the number of postoperative visits actually being provided to Medicare patients, which could have reduced payments for the global surgeries in our sampling frame by an estimated $5,723,292 for Medicare and an estimated $1,666,631 for Medicare patients.

CMS Response

CMS continues to implement MACRA requirements to collect data on the number and level of postoperative visits in order to assess the accuracy of global surgical package valuation, as described above. This process will take time, as there are more than 4,000 global surgery codes. CMS is committed to collecting appropriate data to inform potential changes to the valuation of global surgery fees in accordance with MACRA.

CMS thanks the OIG for their efforts on this issue and looks forward to working with the OIG on this and other issues in the future.

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