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August 2025 | A-05-20-00027

CMS Should Confirm It Is Receiving Medicare Postoperative Visit Data on Global Surgeries When Reporting Is Required

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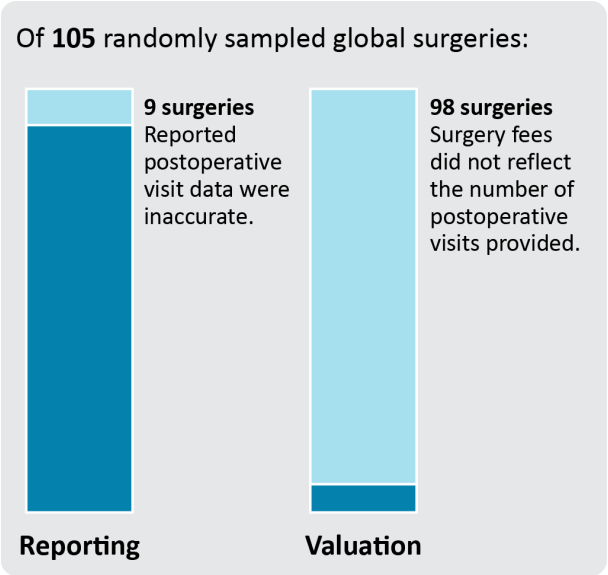
Why OIG Did This Audit

- 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.
- To determine the payment (i.e., the global surgery fee), one element CMS considers is the number of postoperative visits for a typical patient. As part of the Medicare Access and CHIP Reauthorization Act of 2015, Congress mandated that CMS gather information to assist in improving the accuracy of global surgery valuation (i.e., the fees). CMS began to collect this claim information from practitioners, and we audited a sample of the global surgeries. The results of that audit were reported in audit report A-05-20-00021.
- This audit looks at global surgeries without any reported postoperative visits, that were not covered by the congressionally mandated audit. It assessed whether the medical record indicated there were postoperative visits and whether the global surgery fee valuation was accurate.

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, we discovered that fewer visits are provided than are considered in the valuation. Based on our sample results, we estimated that Medicare paid $7.8 million more and that Medicare patients paid $4.8 million more than would have been paid if global surgery fees reflected actual utilization of postoperative visits.



Postoperative visit data gathered by CMS for 9 of 105 sampled global surgeries were inaccurate and cannot assist in improving global surgery valuation as Congress intended. For 98 of 105 sampled global surgeries, we identified that the fees did not reflect the number of postoperative visits provided. Based on these results, improving global surgery valuation is still needed.

What OIG Recommends

We recommend that CMS confirm it is receiving Medicare postoperative visit data from practitioners that it expected would be reporting postoperative visits and notify any practitioners if no postoperative visits are reported.

CMS concurred with our recommendation.

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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 needed 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] 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 verify the accuracy of a sample of the information that CMS gathered to value global surgeries.[7] CMS expressed concern that practitioners required to report postoperative visits were not always reporting, and the congressionally mandated audit

[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 non-physician 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.

[7] This audit, *CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries* (A-05-20-00021), was conducted separately.

would not include global surgeries without any reported postoperative visits. We conducted this audit to address CMS's concern that some practitioners are not reporting any postoperative visits associated with global surgeries when the practitioners are required to report.[8]

OBJECTIVES

Our objectives were to determine whether:

1. the lack of reporting of postoperative visits for certain global surgeries accurately reflected the postoperative visits provided and
2. the global surgery fees reflected the number of postoperative visits provided to Medicare patients for certain global surgeries.

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,[9] 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.[10]

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.[11] A physician service that requires greater resources is assigned a higher relative value that will result in a higher fee schedule amount. Section 1848(c)(2)(B) of the Act requires CMS to review the relative values used in calculating

[8] The global surgeries included in this audit did not have any postoperative visits reported during the global period.

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

[10] 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.

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

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.[12] 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.[13] 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.[14] CMS does not require 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.[15] 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 believes 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.[16]

[12] 42 CFR § 414.40(b)(1).

[13] 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.

[14] 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.

[15] 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.

[16] 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 procedures), 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").[17] CMS required practitioners in reporting States who work in practices that include 10 or more practitioners 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®)[18, 19] 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").[20, 21] 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

[17] 81 Fed. Reg. 80170, 80209-80225 (Nov. 15, 2016).

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[20] 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 non-physician 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.

[21] 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.[22] 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.[23] CMS encouraged those practitioners working in practices with fewer than 10 practitioners to report data, if feasible.

CMS expected practitioners to understand that they must report their postoperative visits if they had 10 or more practitioners in the practice and were located in a reporting State.[24] CMS could not identify which practitioners were required to report their postoperative visits but could identify which practices had practitioners who were expected to report their postoperative visits. CMS prepared a list of practices (referred to in this report as the "practice list") in the reporting States with Taxpayer Identification Numbers (TINs) it identified as having 10 or more National Provider Identifiers (NPIs) associated with the practice that had provided at least 1 CMS-specified global surgery from August 1 through December 2, 2017.[25, 26] CMS recognized that practice size can fluctuate over the year, so the practice list may not accurately identify the practices with practitioners that are required to report their postoperative visits for CMS-specified global surgeries. However, the practice list was the best information CMS had available to identify which practices had the practitioners that CMS expected to report their postoperative visits.

Prior Office of Inspector General Audit

As part of MACRA, Congress mandated that CMS gather information to assist in improving the accuracy of global surgery valuation, and that we audit a sample of the information needed to value global surgeries to verify its accuracy.[27] The results of this separately conducted audit were reported in audit report A-05-20-00021, which included five recommendations to CMS. Four recommendations addressed improving the reporting accuracy of postoperative visits by practitioners, including recommending that CMS: (1) educate practitioners on data collection policy requirements, (2) establish detailed requirements for documenting postoperative visits,

[22] 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.

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

[24] CMS, "New Claims-Based Reporting Requirements for Post-Operative Visits Guide for Practitioners," issued in June 2017; CMS, "Claims-Based Reporting Requirements for Post-Operative Visits Frequently Asked Questions," issued in June 2017.

[25] A TIN is an identification number used by the Internal Revenue Service that is furnished on tax returns and other tax-related documents by individuals or businesses. An NPI is a unique 10-digit identification number issued to individual health care providers or organizations by CMS.

[26] CMS prepared the practice list to send a survey.

[27] MACRA, P.L. No. 114-10, § 523 (Apr. 16, 2015).

(3) identify practitioners or revise which practitioners are required to report, and (4) improve its methodology for data collection. We also recommended that CMS update the global surgery fees to reflect the number of postoperative visits actually being provided to Medicare patients, which we estimated could have reduced payments by approximately $5.7 million for Medicare and approximately $1.7 million for Medicare patients for the global surgeries in that audit's sampling frame.

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

HOW WE CONDUCTED THIS AUDIT

Our audit covered 264,983 CMS-specified global surgeries provided from January 1 through March 31, 2018 (audit period), with claims that included Medicare payments totaling $45.1 million.[28] These global surgeries were provided by practitioners included on the practice list CMS provided, and no postoperative visits using CPT code 99024 were reported for them. The practice list identified the TINs of those practices with practitioners that CMS expected would be required to report their postoperative visits for CMS-specified global surgeries.[29, 30] We used the TINs from the practice list to identify the claims applicable to practitioners that CMS expected to report postoperative visits. 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.[31]

We selected a simple random sample of 105 global surgeries with claims from practices on the CMS practice list for which no postoperative visits were reported that included Medicare payments totaling $15,344. We requested and reviewed the patients' medical records to determine whether any postoperative visits were provided.[32] Using the medical records obtained for 104 of the 105 sampled global surgeries, we determined whether any

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

[29] CMS provided us with the practice list from 2017, prior to our audit period, and said that there was no updated practice list for our audit period.

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

[31] 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.

[32] 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.

postoperative visits were provided.[33] We sent a survey to those practices whose practitioners did not report postoperative visits using CPT code 99024 but had them 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.[34]

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 report all postoperative visits documented in the medical records to CMS. Also, most of the global surgery fees covered by this audit did not reflect the number of postoperative visits practitioners provided during the global period. Specifically:

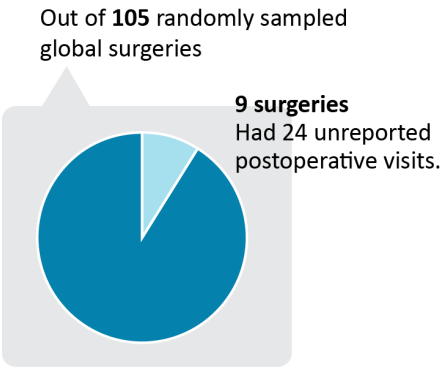
- For 95 of 105 sampled global surgeries, the medical records did not contain documentation to support that any postoperative visits were provided in the global period. As shown in Figure 1 (following page), for 9 of 105 sampled global surgeries, practitioners did not report a total of 24 postoperative visits documented in the medical record to CMS. Two of these global surgeries were provided by practitioners that we

[33] After we selected our sample, we found that one of the selected global surgeries was associated with a practice under investigation. Therefore, we did not obtain medical records for that global surgery and could not review whether any postoperative visits were documented. For purposes of our estimates, we treated that global surgery as if the medical record showed that the number of postoperative visits provided was zero to comport with the absence of claims reporting CPT code 99024 or that did not differ from those considered in the valuation of the global surgery fee.

[34] 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 follow-up visit for the sampled surgery in the patient's medical record and did not receive payment separate from the global fee for the visit.

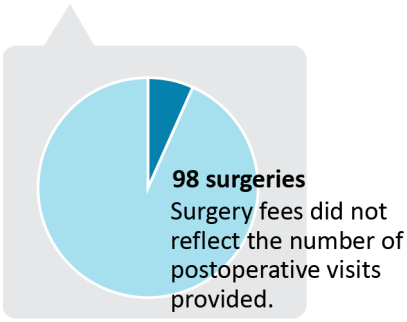
determined were not required to report.[35] We did not review the remaining sampled global surgery (see footnote 33). Based on our sample results, we estimated that, for 22,713 of the 264,983 global surgeries in our sampling frame, there were 60,568 postoperative visits that practitioners provided but did not report to CMS.[36] This occurred because practitioners did not understand CMS's global surgery policy, their billing systems were not properly designed to always submit CPT code 99024 on claims to CMS, they lacked access to medical records associated with postoperative visits performed outside of the practice location, and they were incorrectly shown on CMS's practice list as having at least 10 NPIs in their practice.

Figure 1: Reporting Results



- As shown in Figure 2, for 98 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 considered in valuing the global surgery fee, CMS, in valuing fees for these 98 global surgeries, considered 120.5 postoperative visits more than the number of postoperative visits provided by practitioners.[37] Based on our sample results, we estimate that CMS considered 304,100 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 $7.8 million more and Medicare patients paid

Figure 2: Valuation Results



[35] CMS provided us a practice list that represented those practitioners that CMS thought may meet the postoperative visit reporting requirements. CMS could not identify which practitioners were required to report. Therefore, our sampling frame was based on practitioners for whom CMS expected to report rather than those practitioners that were required to report. Although we determined the practitioners for two surgeries that CMS expected to report were not required, CMS may erroneously consider the lack of reporting for these two surgeries as indication that postoperative visits were not provided.

[36] The 90-percent confidence interval for the number of global surgeries in the sampling frame with unreported postoperative visits was 12,044 to 38,367. The 90-percent confidence interval for the number of postoperative visits that were not reported for global surgeries in the sampling frame was 30,049 to 113,148.

[37] 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 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).

$4.8 million more than would have been paid if global surgery fees reflected actual utilization of postoperative visits.[38]

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."[39] 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 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.[40, 41] Practitioners were required to document that postoperative visits were provided, such as a note documenting the visit in the patient's medical record.[42, 43]

[38] The actual estimates were $7,807,787 and $4,752,987, respectively.

[39] 81 Fed. Reg. 80170, 80209 (Nov. 15, 2016).

[40] 81 Fed. Reg. 80170, 80222 (Nov. 15, 2016).

[41] 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 follow-up E/M visits provided during the postoperative period for reasons related to the original procedure.

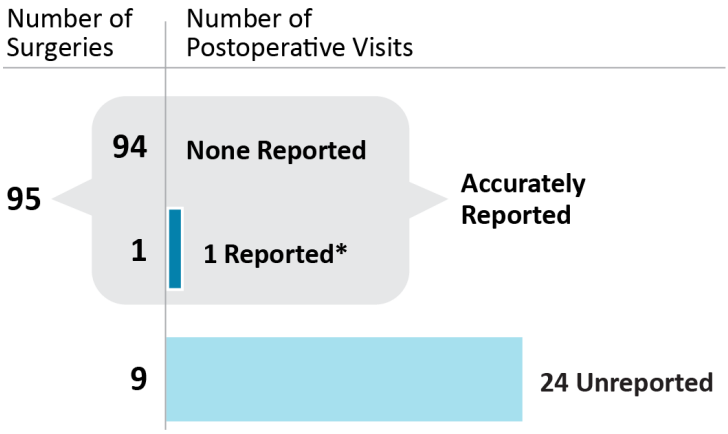
[42] According to CMS's "Claims-Based Reporting Requirements for Post-Operative Visits Frequently Asked Questions," issued in June 2017, practitioners were required to report CPT code 99024 for all postoperative visits furnished during the global period, regardless of the setting in which the postoperative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

[43] 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."

Unreported Postoperative Visits

Of the 105 sampled global surgeries (14 major and 91 minor surgeries), we found that 9 global surgeries were associated with a total of 24 unreported postoperative visits. Two of these global surgeries associated with three unreported postoperative visits were provided by practitioners that we determined were not required to report. Twenty-three of the unreported postoperative visits were associated with eight major global surgeries, and only one was associated with a minor global surgery.

Figure 3: Postoperative Visit Reporting for 104 Sampled Global Surgeries Reviewed



* A practitioner for one sampled global surgery reported a postoperative visit after the end of the global period.

As shown in Figure 3, the practitioners for 94 sampled global surgeries did not document any postoperative visits in the medical records. However, most of these were minor global surgeries for which a follow-up visit with the practitioner may not have been needed.[44] A practitioner for one minor global surgery reported and provided a postoperative visit on the day following the end of the global period. We did not obtain medical records for one global surgery and could not review whether any postoperative visits were documented.[45]

Estimated Number of Postoperative Visits That Were Not Reported

Based on our sample results, we estimated that for 22,713 of the global surgeries in our sampling frame, there were 60,568 postoperative visits that were supported by the patients' medical records, but the practitioners did not report the postoperative visits to CMS.[46]

[44] There were no documented postoperative visits provided for 89 of 91 minor global surgeries in the sample.

[45] See footnote 33.

[46] For purposes of our estimates, we treated the global surgery that was associated with a practice under investigation as if the medical record showed that the number of postoperative visits provided was zero to comport with the absence of claims reporting CPT code 99024 or that did not differ from those considered in the valuation of the global surgery fee.

Postoperative Visits Were Not Reported Mostly Because Practitioners Did Not Understand the Global Surgery Policy, and Practices Did Not Have Billing Systems Capable of Meeting CMS's Data Collection Policy

Based on responses to our survey, we found practitioners did not report postoperative visits using CPT code 99024 because practitioners and their practices' staff: (1) did not understand CMS's global surgery policy, (2) did not have billing systems that were properly designed to always submit CPT code 99024 on claims to CMS, (3) lacked access to medical records of postoperative visits performed outside of the practice location, or (4) were incorrectly included on CMS's practice list as having at least 10 NPIs.

Staff at 7 practices with at least 10 practitioners mentioned they were familiar with CMS's data collection policy and knew practitioners at their practice met the requirements to report postoperative visits. However, not all staff may have understood CMS's global surgery policy and what qualified as a postoperative visit for reporting purposes. In a couple of survey responses, practice staff explained these postoperative visits were missed by staff or incorrectly billed using another CPT code, and that they would provide practitioners and other practice staff additional training.

Further, not all practices' billing systems were adequate to meet the CMS data collection policy. Before CMS implemented its data collection policy, practices did not have a reason to submit claims with CPT code 99024. As a result, some practices did not have systems that could submit claims with CPT code 99024 pursuant to CMS's data collection policy, and they may not have been aware that CMS was not receiving their data. Practice staff in one survey explained their system was set to suppress all zero-dollar charges from generating a claim. Although staff appropriately coded the postoperative visits with CPT code 99024, they did not realize this feature in the system would override CPT code 99024 for claim submission purposes, and only learned there was a problem after we contacted them with our survey. In a couple of other survey responses, practice staff explained that staff properly coded the postoperative visits but did not know why their systems did not submit the claims to the billing clearinghouse or to the MAC.

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. In one survey response, practice staff explained they did not have access to the medical records for multiple locations where postoperative visits were provided.[47]

For the 2 surgeries provided by practitioners that were not required to report, we determined that their practices were incorrectly shown on CMS's practice list as having at least 10 NPIs. Even though these two practitioners were not required to report postoperative visits, CMS may erroneously use data from these practitioners in the rate-setting process because CMS expected these practitioners would be required to report.[48] These data would then show that these practitioners did not provide any postoperative visits for the respective global surgeries which is not accurate.

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

Federal Requirements

Chapter 12, section 40, of CMS's *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.

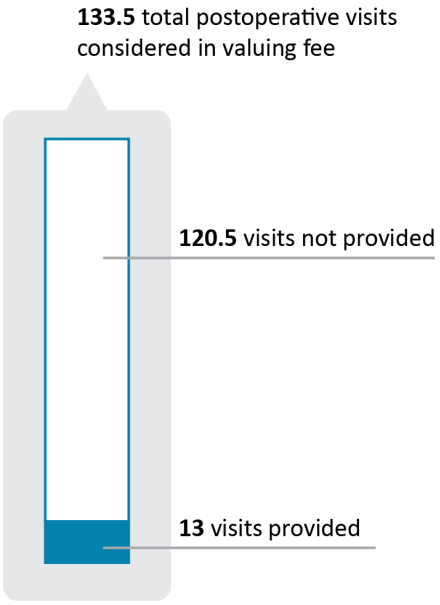
[47] The practitioner for this sampled global surgery saw patients at two clinics – their private practice (billing practice for the sampled global surgery) and another clinic not associated with the private practice. The practitioner first saw the patient at the clinic not associated with the private practice, but that particular global surgery could not be performed at the clinic. Instead, it was performed at the hospital and billed by the private practice. Following surgery, the postoperative care was done at the clinic, as it was closer to the patient's location. Since the postoperative visits did not occur at the private practice's location and the clinic was not associated with the private practice, the billing staff did not have access to those medical records.

[48] CMS has not used the postoperative visit data collected since July 1, 2017, to update the global surgery fees.

The Number of Postoperative Visits Considered in Valuing the Global Surgery Fee Was More Than the Number of Visits Provided

We found that for 98 sampled global surgeries, the number of postoperative visits provided was different from the number of postoperative visits CMS considered in valuing the global surgery. As shown in Figure 4, CMS, in valuing these 98 global surgery fees, considered a total of 133.5 postoperative visits, but practitioners provided a total of 13 postoperative visits, a total difference of 120.5 postoperative visits. For the 98 global surgeries, Medicare paid $3,094 more and Medicare patients paid $1,883 more than would have been paid if global surgery fees reflected actual utilization of postoperative visits.

Figure 4: Valuation for 98 Sampled Global Surgeries



Medicare and Its Patients Paid More for Global Surgeries Than They Would Have Paid if Global Surgery Fees Reflected the Actual Number of Postoperative Visits Generally Provided

Based on our sample results, we estimated that CMS, in valuing fees associated with global surgeries in our sampling frame, considered 304,100 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 $7.8 million more and Medicare patients paid $4.8 million more than would have been paid if global surgery fees reflected actual utilization of postoperative visits.

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."[49] 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 it 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

[49] 81 Fed. Reg. 80170, 80209 (Nov. 15, 2016).

Physician Time File, CMS made changes to the number of postoperative visits considered for only 51 global surgeries.[50, 51]

CONCLUSION

We separately conducted the congressionally mandated audit of global surgery information, and in that audit report, we made recommendations to CMS that addressed improving the reporting accuracy of postoperative visits by practitioners and considering actual data in valuing global surgery fees. We maintain that, when CMS acts on those recommendations, it will also address some of the concerns identified in this audit. For example, when CMS updates its valuation of the global surgery fees to reflect the number of postoperative visits actually being provided to Medicare patients, we expect it could reduce global surgery payments. If CMS had considered the number of postoperative visits provided for the global surgeries covered by this audit, it could have reduced payments for the global surgeries in our sampling frame by an estimated $7,807,787 for Medicare and an estimated $4,752,987 for Medicare patients. To help improve the data collection policy and valuing global surgery fees, we recommend that CMS implement the recommendations from the congressionally mandated audit report.

RECOMMENDATION

We recommend that the Centers for Medicare & Medicaid Services confirm it is receiving CPT code 99024 data from practitioners that it expected would be reporting postoperative visits and notify any practitioners if no postoperative visits are reported.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendation and described actions that it planned to take to address our recommendation. Specifically, CMS stated that it will confirm that providers expected to report postoperative visits are doing so and will reach out to any of those who have reported no postoperative visits. CMS also provided separate technical comments that we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix G.

[50] 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.

[51] 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.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 264,983 CMS-specified global surgeries provided to Medicare patients from January 1 through March 31, 2018 (audit period), with claims that included Medicare payments totaling $45,122,736, for which practitioners (or practitioners in the same practice) in the reporting States did not report postoperative visits using CPT[52] code 99024 in Medicare Part B claims data when CMS expected them to do so.[53] CMS provided a practice list of TINs used to identify the claims for these practitioners.

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. We considered only non-overlapping surgeries because 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.

From the 264,983 CMS-specified global surgeries, we selected a simple random sample of 105 global surgeries with claims that included Medicare payments totaling $15,344.

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 June 2025.

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[53] 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;[54]
- using the practice list CMS provided, identified a sampling frame of 264,983 CMS-specified global surgeries provided from January 1 through March 31, 2018 (see Appendix D);
- 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;

[54] 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.

- requested and received medical records for 104 of the 105 global surgeries and their postoperative visits from the billing practice and the facility where the surgery took place (see footnote 33);

- for each of the 104 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 reaffirmed there were not any postoperative visits reported during the postoperative period;[55]

    - 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 the number of postoperative visits provided to the patient based on medical record documentation but not reported using CPT code 99024;

    - sent a survey to those practices that we found did not report postoperative visits using CPT code 99024;

- used the sample results to estimate the number of surgeries with unreported postoperative visits and the number of unreported postoperative visits 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 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 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

[55] For one minor sampled global surgery, we noticed a practitioner reported CPT code 99024 for a postoperative visit provided a day after the end of the postoperative period.

- 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
CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries	A-05-20-00021	6/26/2025
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[56] 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 times or

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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.[57]

FEDERAL GUIDANCE

In June 2017, CMS responded to frequently asked questions regarding the data collection requirements.[58] 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 they are included in the global period.

CMS also issued a guide for practitioners regarding the reporting requirements.[59] 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, such as a note documenting the visit in the patient's medical record, to demonstrate that postoperative visits were provided and that CPT code 99024 was correctly used.

[57] 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.

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

[59] 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 264,983 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 $45,122,736. The global surgeries in the sampling frame were provided by practitioners in nine reporting States (footnotes 5 and 6) and for which practitioners (or practitioners in the same practice) did not report postoperative visits using CPT[60] code 99024 when CMS expected them to do so 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.[61] 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 at the time of preparing the sampling frame (footnote 33).

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.

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[61] We used the TINs from the practice list to identify the claims applicable to practitioners that CMS expected to report postoperative visits.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to estimate (for the sampling frame): (1) the number of surgeries with unreported postoperative visits, (2) the number of unreported postoperative visits, (3) the difference between the number of postoperative visits provided and the number of postoperative visits considered in valuing the global surgery fee, and (4) the 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 and 5).

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**
264,983	$45,122,736	105	$15,344

Table 2: Sample Results for Global Surgeries With Unreported Postoperative Visits

Number of Sampled Global Surgeries With Unreported Visits	Number of Postoperative Visits for Sampled Global Surgeries With Unreported Visits
9	24

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	98
Difference in number of postoperative visits	120.5
Associated dollar value of Medicare payments	$3,094
Associated dollar value of Medicare patient payments	$1,883

ESTIMATES

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

Estimates	Number of Global Surgeries With Unreported Postoperative Visits	Number of Unreported Postoperative Visits
Point estimate	22,713	60,568
Lower limit	12,044	30,049
Upper limit	38,367	113,148

Table 5: 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 Dollar Value	
Estimates	Difference in Number of Postoperative Visits Considered and Provided	Medicare Payments	Medicare Patient Payments
Point estimate	304,100	$7,807,787	$4,752,987
Lower limit	278,868	6,825,435	4,139,111
Upper limit	335,256	8,932,489	5,453,331

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 global surgery fee:** We identified the number of E/M visit CPT[62] codes considered in valuing the global surgery fee for each sampled global surgery CPT code from the Physician Time File. For example, a gastric bypass surgery (CPT code 43644) has a total of seven E/M visits considered in valuing its fee.

Table 6: Number and Type of E/M Visit CPT Codes in the Physician Time File for CPT Code 43644

	Office Visits			Hospital Care		Hospital Discharge
Surgery CPT Code	**CPT Code 99212**	**CPT Code 99213**	**CPT Code 99214**	**CPT Code 99231**	**CPT Code 99232**	**CPT Code 99238**
43644	1	1	1	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 gastric bypass 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 7: Physician Fee Schedule Amounts for E/M Visit CPT Codes at Ohio Facility

			Office Visits			Hospital Care		Hospital Discharge
MAC Number	**Locality Code**	**Fee Type**	**CPT Code 99212**	**CPT Code 99213**	**CPT Code 99214**	**CPT Code 99231**	**CPT Code 99232**	**CPT Code 99238**
Ohio MAC Number	Ohio Locality Code	Facility	$25.33	$50.99	$78.08	$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 gastric bypass surgery example, the lowest E/M visit fee would be $25.33.

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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 surgery to calculate the allowed charge for one E/M visit.[63, 64] Only 15 of the 105 sampled global surgeries had at least 1 of these adjustments. There were no payment adjustments to the fee for the Ohio gastric bypass surgery in our example, so we used $25.33 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.[65] For our example, the allowed charge for an Ohio gastric bypass surgery is $1,764.92. The patient had no deductible, so they paid only the 20-percent coinsurance of $352.98. The remaining 80 percent ($1,411.94) was reduced by 2 percent for sequestration ($28.24), and Medicare paid the practitioner $1,383.70.

Table 8: 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)]
$1,764.92	$352.98	0.2000	$28.24	$1,383.70	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

[63] 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.

[64] 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 gastric bypass surgery example, we would use 98 percent of $25.33, which is $24.82, as the allowed charge for one E/M visit.

[65] 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, 89 of the 105 sampled global surgeries had sequestration adjustments that reduced Medicare's payment by 2 percent. The other 16 of the 105 sampled global surgeries did not have sequestration applied because the patient's deductible was not yet met; therefore, the patient-paid proportion was 100 percent and Medicare-paid proportion was 0 percent for these 16 sampled global surgeries.

CMS in valuing the global surgery fee to determine the difference. Table 9 includes our finding for the gastric bypass global surgery in our sample.

Table 9: Example of Calculating the Difference Between the Number of Postoperative Visits Considered in Valuing the Global Surgery Fee and the Number of Visits Provided

	Number of Visits
(A) Postoperative visits considered by CMS in valuing global surgery fee	7
(B) Postoperative visits provided as reflected in the medical records	4
(C) Difference in postoperative visits [(A)–(B)]	3

Depending on the number of postoperative visits provided, these calculations resulted in a positive or zero difference for each sampled global surgery. None of the global surgeries in our sample had more visits provided than the number of visits considered by CMS in valuing the global surgery fees.

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 10: Example of Calculating the Medicare Paid and Patient Paid Shares of the Dollar-Value Differences for the Difference in Postoperative Visits

(A) Difference in postoperative visits	3
(B) Lowest E/M visit allowed charge	$25.33
(C) Dollar value of difference [(A) x (B)]	$75.99
(D) Medicare proportion	0.7840
(E) Medicare paid share of dollar-value difference [(C) x (D)]	$59.58
(F) Patient proportion	0.2000
(G) Patient paid share of dollar-value difference [(C) x (F)]	$15.20

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 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: July 8, 2025

TO: Carla J. Lewis
Acting Deputy Inspector General for Audit Services

FROM: Dr. Mehmet Oz
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *CMS Should Confirm It Is Receiving Medicare Postoperative Visit Data on Global Surgeries When Reporting Is Required* (A-05-20-00027)

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.

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.[1] 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.

[1] 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 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

We recommend that the Centers for Medicare & Medicaid Services confirm it is receiving CPT code 99024 data from practitioners that it expected would be reporting postoperative visits and notify any practitioners if no postoperative visits are reported.

CMS Response

CMS concurs with this recommendation. CMS will confirm that providers expected to report postoperative visits are doing so and will reach out to any of those who have reported no postoperative visits.

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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