

September 6, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
PO Box 8016
Baltimore, MD 21244-8016

Subject: CMS-1770-P; Medicare Program; CY 2023 Payment Policies Under the
Physician Payment Schedule and Other Changes to Part B Payment Policies—
Global Surgical Packages

Dear Administrator Brooks-LaSure:

On behalf of the undersigned national surgical professional organizations and the members and patients we serve, we are writing to express our ongoing concerns with the Center for Medicare & Medicaid Services' (CMS) failure to resolve outstanding issues regarding the Medicare Physician Fee Schedule (PFS) global surgical package. We are particularly frustrated that CMS has refused to appropriately adjust the 10- and 90-day global surgery codes to reflect recent increases in the evaluation and management (E/M) codes — even though the agency has done so each time the E/M codes were revalued to comply with the Medicare statute's relativity and specialty payment differential requirements.

For nearly a decade, the surgical community has engaged in a good-faith dialogue with the agency, yet issues related to the global surgery codes remain unresolved. While we believe there is little more to say on this subject, given the extensive comments and input that CMS has received, the surgical community nevertheless reiterates our willingness to work with the agency to ensure that the global surgery codes are appropriately valued. To this end, we offer the following comments and recommendations in response to your request for strategies for improving global surgical package valuation in preparation for future rulemaking.

Our comments address the questions CMS posed in the proposed rule and are organized in the order in which they appear in the *Federal Register*.

Ideas for other sources of data that would help assess global package valuation (including the typical number and level of E/M services), as well as CMS' data collection methodology and the RAND report findings.

The surgical community strongly believes that the American Medical Association (AMA)/ Specialty Society RVS Update Committee (RUC) is the appropriate mechanism for addressing potentially misvalued codes, including the global surgical codes. CMS should, therefore, avail itself of the RUC's Relativity Assessment Workgroup (RAW) process, using objective screens to identify potentially misvalued global codes. There is no need for the agency to consider

alternative methods or sources of data. The RUC is a well-established, collaborative process, and there is no compelling reason for the agency to deviate from it when evaluating the global surgery codes.

Furthermore, we have serious concerns with the research conducted by RAND and strenuously object to the agency using the RAND reports as a basis for revaluing the global codes, as discussed below.

RAND Report 1, Claims-Based Reporting of postoperative Visits for Procedures with 10- or 90-Day Global Periods

From July 1, 2017, to June 30, 2018, CMS required groups with ten or more practitioners in nine states (Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island) to report on their postoperative visits during the global period for 293 common procedures using CPT code 99024 (postoperative follow-up visit). This data collection effort was ill-conceived and thus incomplete and cannot reasonably be used to revalue the global surgery codes. Nor will another similarly designed effort yield better results.

The first flaw in the RAND methodology stemmed from the lack of awareness about the data collection and mandated reporting, as well as other challenges. These concerns were highlighted and brought to CMS' attention prior to and during the data collection but were never adequately addressed:

- The mandate to report 99024 layered new administrative burdens on practices and was not compatible with all electronic health record systems;
- There was significant confusion about which physicians were required to report and the duration of the reporting period;
- The use of 99024 contradicted coding rules and conventions;
- Billing clearinghouses typically did not recognize zero-charge bills and physician practices encountered difficulties reporting 99024 as electronic health record (EHR) systems blocked attempts to submit claims for the code because it lacked any dollar value; and
- Small practices were excluded from the data collection requirement, thereby skewing the results.

Any one of these reasons would justify the conclusion that the data collected was incomplete and the data collection method was faulty. Yet, CMS and RAND persisted in their analyses and drew incorrect conclusions from it that postoperative visits were not taking place. Consider the following example of the faulty methodology. The raw data collected by RAND showed that thoracic surgeons performed 276 10-day global procedures with only 40 instances of code 99024 reported. Additionally, cardiac surgeons performed 144 10-day global procedures with only 25 instances of code 99024 reported. ***There are no 10-day global procedures on the list of codes for mandatory reporting that cardiac or thoracic surgeons would typically perform.*** Instead, all the codes typically attributed to cardiac and thoracic surgery on the mandatory reporting list were ***90-day global codes*** (32480, 32663, 33405, 33426, 33430, 33533 and 33860).

The RAND report had other glaring errors. For example, in the CY 2019 proposed rule, CMS stated that cardiac and thoracic surgeons reported at least one 99024 visit code 84% of the time. However, the RAND report does not reference either of these specialties, leaving one to assume that they are included in the “all other specialties” category, which had lower reporting rates. It is puzzling how a specialty with a relatively high percentage of reporting at least one postoperative visit could have fallen off this dramatically for subsequent reporting, leading to the conclusion that the RAND analysis was flawed due to a misinterpretation of coding practices. An additional example from cardiac surgery demonstrates another shortcoming of the RAND analyses. RAND stated that it only evaluated “clean” procedures for global periods during which another procedure was not reported. Only 5.9% of coronary artery bypass graft (CABG) surgery is performed as a single-vessel procedure. However, it is coded as a single vessel CABG with add-ons for additional vessels. ***If RAND interpreted the additional vessels as additional procedures and discarded all multi-vessel CABG procedures, RAND discarded 94% of the instances of one of the most common procedures performed by a cardiac surgeon.*** RAND also excluded claims with assistant at surgery modifiers (-80, 81 or -AS). Cardiac and thoracic surgeons utilize an assistant at surgery for most procedures, again calling into question the validity of the conclusions drawn by RAND in this report.

While RAND recognized the limitations in its data collection methodology using the claims-based reporting of postoperative visits for procedures with 10- or 90- day global periods, it nevertheless drew inappropriate conclusions. For example, RAND assumed that if a surgeon did not report code 99024, a visit did not take place. The “sensitivity analysis” performed by RAND assumed that just because a physician reported code 99024 once, they would do so again for the same patient. As stated above, multiple reasons explain the data incompleteness, including confusion over the reporting requirements and EHR/billing system challenges. Furthermore, RAND did not distinguish between postoperative visits performed in the hospital setting and those in the office. This was problematic for many surgeons, whose patients could spend several postoperative days in the hospital. For surgeons who used a separate EHR system in their office and then another different EHR system in the hospital where they perform surgery, there were undoubtedly challenges in capturing and submitting claims for postoperative inpatient hospital visits. Yet, CMS and RAND persisted in claiming that the postoperative visits were not taking place.

RAND Report 2: Survey-Based Reporting of postoperative Visits for Select Procedures with 10- or 90-Day Global Periods

CMS also contracted with RAND to conduct a survey to collect additional data on postoperative services, including the level of postoperative services. This survey was the agency’s attempt to collect information on the value of the postoperative visits because recording code 99024 would only provide a tally and not information on the level of visits. RAND launched a pilot survey in the fall of 2017 with a sample size of 557 practitioners and received only a single complete response. Following this setback, CMS and RAND decided to significantly narrow the scope of this survey initiative to only three high-volume services: cataract surgery (CPT code 66984), hip arthroplasty (CPT code 27130) and complex wound repair (CPT codes 13100, 13101, 13120, 13121, 13131, 13132, 13151 and 13152).

That CMS would attempt to glean anything from this analysis that could be applied broadly across all types of surgery is folly and imminently harmful. Beyond the obvious limitations of a survey of fewer than one thousand physicians who perform these procedures, RAND's main conclusion in the second report is flawed. RAND asserted that the average visits were somewhat shorter than anticipated for cataract surgery (16.4 minutes vs. 19.4 minutes) and hip arthroplasty (22.9 minutes vs. 29.6 minutes) and longer for complex wound repair (21.8 minutes vs. 16 minutes). However, RAND misinterpreted the findings of their survey data as they only compared the survey physician time "on the day of the visit" to the CMS physician time file, where the pre-service and post-service time of E/M services are not specific to the date of the encounter. The researchers also inappropriately excluded nurse practitioner and physician assistant time from their visit time comparison analysis. Additionally, in 2019, time was not the determining factor in the selection of the level of inpatient or office visit. Instead, the level of code reported was based on at least two of three key components; history, examination, and/or medical decision making.

Rand Report 3: Using Claims-Based Estimates of postoperative Visits to Revalue Procedures with 10- and 90-Day Global Periods

This third study used the reverse building block methodology to estimate the change in Medicare payment based on RAND's summary data from the first study. The analysis included in this study is extremely flawed and disingenuous. The researchers completely disregarded the "robust reporters" concept highlighted in the first study. They did not attempt to filter out the 54 percent of eligible providers that did not participate in the data collection initiative. If 54 percent of eligible providers are assumed never to perform postoperative visits simply because they were unaware or unable to participate in the data collection project, then the median number of visits for many surgical global codes would be zero, irrespective of what participating physicians reported. Also, as no specialty achieved a 100 percent participation rate, all codes included in the study would have been undercounted to some extent.

Consider an example from neurosurgery. The numbers extrapolated by RAND based on their analysis of claims data bear no resemblance to actual clinical practice. For example, two of the 15 neurosurgical codes captured by the RAND analysis — CPT codes 61312 and 61510 — represent craniotomy codes, one for the evacuation of a hemorrhage and the other for the resection of an intracranial tumor. Both of the patient populations represented by these procedures are medically complex. They are typically seen multiple times during the 90-day global period — in the hospital (often in the intensive care unit) and office, post-hospital discharge. ***However, according to the RAND analysis, the most common number of postoperative visits for these two procedures was zero, meaning that RAND concluded that neurosurgeons never see patients who have undergone these procedures in the postoperative period.*** Obviously, this is grossly inaccurate and highlights the lack of face validity and fidelity of the RAND data.

The surgical community also objects to the "reverse building block methodology" to systematically reduce work RVUs for services. We contend that the reverse building block methodology, or any other purely formulaic approach, should never be used as a methodology to value services. The reverse building block methodology is particularly inappropriate since

magnitude estimation has been used to establish work RVUs for physician services since the first Medicare PFS was published in 1992. This methodology, for example, ignores the care coordination work performed during the global surgical period, as evidenced by the flawed analysis of the RAND hip arthroplasty survey.

Implementing the methodology outlined in this RAND report would result in baseless reductions (e.g., 18.4% for cardiac surgery, 18.1% for surgical oncology and 13.5% for neurosurgery) in total Medicare payment for many surgical specialties, putting at risk access to care for Medicare beneficiaries.

Final thoughts on the RAND reports and other data sources

With so many questions and flaws in the methodology used to analyze the data, it would be irresponsible for CMS to make any policy changes based on these data and analyses. Furthermore, the new E/M coding structure developed by the RUC and adopted by CMS renders the RAND reports moot. ***If CMS believes that global surgery codes are misvalued, then the agency should employ the processes already available to address misvalued codes: the RUC process.***

Whether the postoperative health care landscape has changed in ways that impact the relevance of the global packages, including coordination of care and use of medical technology, as well as the recent public health emergency. Specifically, have changes impacted:

- **The number and level of postoperative E/M visits needed to provide effective follow-up care to patients;**
- **The timing of when postoperative care is being provided; and**
- **Who is providing the follow-up care.**

Number and level of postoperative E/M visits needed to provide effective follow-up care to patients

The postoperative health care landscape has changed in ways that increase the relevance of the global surgical packages, with innovative techniques and medical technology that allows patients that previously would not have been candidates for surgical procedures to have these life-altering and life-saving procedures. At the same time, surgeons are treating more patients with chronic health conditions, such as diabetes and hypertension, which can complicate postoperative surgical care and require surgeons to coordinate pre- and postoperative care with other physician specialties who are treating the patient for their chronic health care conditions. Thus, in certain situations, surgeons may need to see the patient in the office more frequently and/or receive more calls as the patients and their families navigate postoperative care issues such as infection, wound care, pain, ambulation, medication management and continence. In addition, the shift of care from the inpatient to the outpatient setting, as well as pressure to send patients home sooner after inpatient surgery, has not decreased total work but instead has shifted work from the facility to the office/outpatient setting. ***Thus, this evolution in the complexity of health care delivery has led to the undervaluation rather than overvaluation of many global surgical codes.***

Furthermore, the changes made to the E/M codes now recognize total time or level of medical decision making to determine the level of care being provided. Postoperative services that have always been provided to patients as part of postoperative care in a global surgical package may now not be fully captured and articulated with new E/M coding rules. For example, surgeons may now take out foley catheters, drains, staples and stitches in their offices during follow-up visits for surgical procedures, rather than doing so in the hospital while the patient was still admitted. These minor procedures are being conducted during extended office visits. Their time and intensity are represented by office visit codes in the global surgical package even though they are procedures. Depending on the type of surgery, most of these visits occur within the first week to 10 days post-surgery. Then a surgeon needs to see that patient again to ensure healing and no infection. Wound care and healing checks are not a service that should be provided via a telehealth visit. Similarly, managing a patient's postoperative pain requires a face-to-face visit to ensure that any prescriptions are necessary and to review other options for postoperative pain control.

The timing of when postoperative care is being provided

As mentioned above, technology has allowed more patients with chronic health conditions to be eligible for surgical procedures. This means that surgeons are treating sicker patients, and more complicated E/M services are provided during the global period. For most surgical procedures, the surgeon is the “captain of the team” for that patient before, during and after their surgical procedure — even beyond the 90-day global period. Global surgical packages support a coordinated, team approach to health care which is the best way to ensure that patients receive the highest quality and most efficient care. The concept of global payments, pioneered with surgical procedures, incentivizes providers to coordinate care — a concept that is emulated in some Center for Medicare and Medicaid Innovation (CMMI) demonstration projects. Since their inception, CMS has been using global surgical packages — intentionally or unintentionally — to shift risk to physicians.

Most surgical patients are first seen within a week to 10 days post-surgery to check for infection, wound healing, etc. For some surgeries, it might be within two to three days if a foley catheter or drain needs to be removed. Some postoperative visit work — such as contacting other providers; work related to durable medical equipment, prosthetics, orthotics and supplies; or home health orders — is also done on the day of the office visit or may be performed at subsequent visits if, for example, the physician is called to another surgery.

Surgeons also perform work during the global period “between visits” in addition to what is considered work “after visits,” such as the review of lab results or images to prepare to bring the patient into the office for an additional postoperative visit. From a quality standpoint, this non-patient-facing work is necessary to monitor the patient's progress, adjust/identify appropriate postoperative care and avoid a host of complications.

Furthermore, CMS must understand that the E/M visits in a global surgical package represent a “typical” or straightforward patient. They do not represent a more complicated or complex patient at a higher risk for complications and wound care issues that may need to be seen in the

office several times post-surgery. With CMS deciding to use “standard packages” for the number of office visits for 10- and 90-day global surgical periods, the risk has been placed on the surgeon to manage those resources for the number of visits that the patient needs.

Who is providing the follow-up care

Surgeons work with a team of health care providers to “wrap” services around their surgical patients. Whether the surgeon, physician assistant, nurse practitioner or other group practice physicians, these clinicians all contribute to the patient’s postoperative care during the global period. This “captain of the team” approach ensures appropriate, high-quality care for a single global payment.

Whether, or how, recent changes in the coding and valuation of separately billable E/M services may have impacted global packages (e.g., the expansion of payment for nonface-to-face care management services).

The recent changes in the coding and valuation of separately billable E/M office/outpatient services now make them more, not less, representative of the level of work and effort provided by surgeons during their postoperative office visits by expanding the payment to account for all the nonface-to-face E/M services and time. The RUC, which represents the entire medical profession, recognized this when it voted overwhelmingly (27-1) in 2019 to recommend that the full, incremental increase of work and physician time for office visit E/M codes be incorporated into the work and time for each CPT code with a global period of 10-days, 90-days and MMM (maternity care).

The RUC also recommended that the changes to the practice expense inputs should be incorporated into the practice expense inputs for the office visits within the global periods. In the CY 2021 PFS rule, CMS used the RUC recommendation as part of the rationale for proposing to increase the work RVUs and practice expense inputs of the maternity services codes and select other bundled services (but inappropriately refused to update the global surgery bundled codes). As mentioned above, surgical practices provide a wide range of postoperative services during the global period that aligns with the manner in which the new separately billable E/M codes are reported and valued.

Whether global packages, and especially those with 10- and 90-day global periods, continue to serve a purpose when physicians could otherwise bill separately not only for the postoperative E/M visits they furnish, but also for aspects of postoperative care management they furnish for some patients. Generally, what, if any, components of preoperative or postoperative care are currently only compensated as part of payment for global packages.

The surgical community strongly believes that the global code structure should remain in place — particularly in light of the fact that CMS and other payers are moving toward bundled payments. As noted above, the global surgical package concept is one that CMMI and

others are building on to establish new, value-based care models. To reverse course in the fee-for-service system makes no sense and is inconsistent with the evolution of health care delivery.

Before Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), CMS had proposed unbundling the global surgical package so surgeons would be required to bill their patients separately for each postoperative visit. We strenuously oppose such an approach, as we did when CMS announced this plan. Eliminating the global surgical package would create a huge and unnecessary burden for all stakeholders — patients, providers and payors — affecting more than 4,200 services in the Medicare PFS with a 10- or 90-day global period, representing well over one-third of all CPT codes. Patients would be responsible for paying for each post-op visit separately, disadvantaging the sicker and more vulnerable patients who require more visits. Providers would be subjected to submitting additional claims, and the Medicare Administrative Contractors would have to process and pay them. When CMS first proposed eliminating the global surgical package, the AMA estimated that this would result in 63 million additional claims per year to account for postoperative evaluation and management services; thus adding unnecessary costs to the claims processing system. In addition, there is no way to know how private payors would choose to treat global periods, creating potential confusion and processing delays.

As previously discussed, many postoperative services are included in the 10- and 90-day global codes that may not be reflected in the separately billable E/M codes. These postoperative services represent actual dollar cost outlays by surgeons, both for supplies as well as labor, that are fairly paid for using the existing methodology in the 10- and 90- day global codes but would be completely unpaid if surgeons were left to bill for them by using E/M codes. Examples of these services include items such as:

- Dressing changes;
- Local incision care;
- Removal of the operative pack;
- Removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints;
- Insertion, irrigation and removal of urinary catheters;
- Routine peripheral intravenous lines;
- Nasogastric and rectal tubes; and
- Changes and removal of tracheostomy tubes.

Furthermore, eliminating the global surgical package would necessitate a colossal undertaking requiring the revaluation of thousands of surgical codes. CMS cannot just apply a reverse building block methodology to back out the E/M services from the existing global codes (previous modeling of such an approach demonstrated that many codes would have zero work RVUs under such an approach). Eliminating the global surgical package also has implications for how practice expense per hour and professional liability insurance costs would be appropriately accounted for. Additional policies impacted include the multiple surgeries reduction, bilateral payment reduction, co-surgeons and team surgeon payment reductions, and assistant-at-surgery reduction. These reductions are primarily based upon, and justified by, the redundancy of bundled postoperative E/M visits between multiple services or when multiple surgeons are performing the same surgery.

If CMS eliminates the global surgical package, we are concerned that requiring patients to pay a co-pay for each follow-up visit could dissuade them from returning for follow-up care and adversely affect surgical outcomes. Further, paying separate co-pays for follow-up care can cause patients to perceive the net payments as larger, given the frequency of payment required. The increased burden on sick patients to pay these extra bills could be overwhelming. It is also important to remember that any negative impact due to extra co-pays and deductibles paid by Medicare beneficiaries could only be calculated for a beneficiary with a clinical course resembling the “typical” patient. The “typical” patient, by definition, does not include unusual or non-typical complications; there are patients who will require more postoperative visits than are currently included in the global packages. Those patients, perhaps sicker or with more significant complications and/or chronic health conditions/co-morbidities, will then be subject to higher or more co-pays due to cost sharing for every visit.

In short, CMS should maintain the current global surgical package and use the AMA RUC process to address potentially misvalued codes. To do otherwise would be unnecessarily complicated, disruptive and costly.

Perceived misalignment between the E/M visits included in global packages and separately billable E/M services, including thoughts on how this current tension reflects on global payment valuation and the appropriate methodology for determining appropriate values for global packages.

The agency continues to believe there may be misalignment between the E/M services included in the global codes and separately billable E/M services and would like to hear from the public on how this “current tension” reflects on global payment valuation and the appropriate methodology for determining appropriate values for global packages. We believe an extensive process already exists to determine the appropriate value for global services through the RUC. CMS may accept, modify, or reject the RUC recommendations, thereby giving the agency the ultimate determination of whether the E/M services reflected in the global package are accurate. ***If CMS believes that specific global codes are “misvalued,” the agency should utilize the RUC’s RAW process, using objective screens to identify potentially misvalued global codes.*** Once identified, the RUC can then follow its process for reviewing the global codes to ensure the values accurately reflect the actual services and postoperative visits being provided to patients.

When RUC survey respondents provide their input on physician work required to perform a service, the postoperative visits are part of their work RVU recommendation when using magnitude estimation for total work. Instead of relying on extrapolated data, responses from RUC surveys come directly from the physicians treating the patients and doing the work. Based on our experience with the RUC process, we believe that the medical decision making during postoperative visits is comparable to separately billable E/M services. Comorbidities do not disappear just because it is a postoperative visit. Surgeons, therefore, must also consider the complexity of problems and complications and/or morbidity or mortality of patient management, just as they would do for a separately billable E/M visit.

To illustrate the medical decision making involved in postoperative visits, CPT 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis without endoscopic cyclophotocoagulation) can be used as an example. Per Table 2: Levels of Medical Decision Making (MDM) in the CPT codebook, which CMS adopted effective January 1, 2021, the number and complexity of problems addressed at the postoperative visits for CPT 66984 are typically described as low, which correlates to E/M CPT 99213. Either one acute uncomplicated problem (e.g., recent cataract surgery that was successful with a diagnosis of nuclear sclerosis, cortical cataract or posterior subcapsular cataract) or one stable chronic condition (e.g., nuclear sclerosis, cortical cataract or posterior subcapsular cataract) are addressed. The amount and/or complexity of data to be reviewed and analyzed is typically minimal, thus correlating to E/M CPT 99212. Finally, the risk of complications and/or morbidity or mortality of patient management typically meets the criteria for low MDM, which correlates to E/M CPT 99213. For a typical cataract surgery patient, prescription drug management is performed at every visit in the postoperative period changing the dosages of steroids and adding or adjusting medications in the immediate postoperative or later postoperative periods to adjust for pressure elevations, corneal edema, epithelial defects, postoperative keratitis, dry eye and other issues. To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded. Thus, CPT 99213 would be justified based on current E/M billing rules for a typical postoperative visit during the CPT 66984 global surgical package.

It is important to note that CPT 66984 underwent revaluation during the 2019 rulemaking cycle, and CMS agreed with the RUC's recommendation that the global surgical payment period includes three postoperative visits for CPT 66984 (one level 2 and two level 3 visits). As shown above, based on the updated medical decision making rules for the selection of E/M code level, for the typical patient, ophthalmologists are actually doing three level 3 visits within the global surgical period and, therefore, should be receiving higher E/M reimbursement for CPT 66984. Given the agency's acceptance of these visits, there is no reason ophthalmologists should be paid less for E/M visits than other physicians who provide the same service per visit. Yet, failing to adjust the global codes to account for the increased values of the stand-alone E/M services is equivalent to paying some physicians less for providing the exact same level of E/M services in the postoperative period.

Additional input on the RAND methodology, including advantages and drawbacks of applying the RAND methodology to revaluation and specific alternatives, including: (1) requesting the RUC to make recommendations on new values; or (2) another method proposed by the public.

As thoroughly discussed above, the RAND methodology is inherently flawed and based on incomplete data. Also, the RAND work assessed the global code package regarding how E/M services were previously reported and valued. *As such, CMS must not use the RAND reports as a basis for valuing the global surgery codes. Instead, the agency should use the RUC process for this purpose.* There is no better process available. The RUC is well-established, transparent and generally fair, and it has the added advantage of having the buy-in of the medical profession.

Strategies for a revaluation process for global services, including the following:

- (1) Evaluating all 10- and 90-day global packages at one time;**
- (2) Revaluing only the 10-day global packages;**
- (3) Revaluing 10-day global packages and some 90-day global packages;**
- (4) Relying on the Potentially Misvalued Code process to identify and revalue misvalued global packages over the course of many years; or**
- (5) Additional ideas, including ancillary considerations such as timing considerations for implementation of any future strategy.**

As we have previously commented, by failing to increase the value of postoperative visits included in 10- and 90- day global surgery packages to correspond with the increased values for stand-alone E/M office visits and other selected bundled services that took effect on January 1, 2021, CMS is arbitrarily devaluing surgical post-op office visits without applying the same rigorous analysis employed by the RUC and reviewed by the agency, that determines the relative value of each individual service in the physician fee schedule. As a result, the relativity of the fee schedule has been compromised, which is a fundamental underpinning of the Resource-Based Relative Value Scale. This relativity preserves the integrity of the PFS and ensures that office visits are valued consistently, regardless of the specialty providing the service.

Cataract surgery (CPT 66984), which has the highest Medicare allowed charges of any 10- or 90-day global surgical code, is an excellent example of why CMS' current policy is flawed and illustrative of the relativity distortion created by the inequity between the E/M stand-alone visits and the postoperative visits in the global surgical package. This global surgical code was recently revalued by the RUC and reaffirmed by CMS as including three postoperative visits following cataract surgery in the 90-day global period (two level 3 visits and one level 2 visit). In addition, during the RUC review of the revised office/outpatient E/M services codes (99202-99215), the ophthalmology median survey work and time data were similar to the primary care survey data, as well as the median survey data of all specialties combined. Since CMS accepted the RUC recommended work and time for these codes, there is no reason why ophthalmologists should not be paid at the same level of E/Ms as other physicians when they are providing the same level of service per patient.

Further, CMS has acknowledged and recognized the importance of maintaining relativity. Each time stand-alone E/M codes have been revalued since their inception in 1992, the postoperative E/M services included in the global surgical codes have also been increased. Again, CMS should be consistent with its prior policy and increase the values of the global surgical codes.

As stated above, we continue to support the RUC, which is the most representative consensus of medical and surgical specialties, and the misvalued code identification process as the appropriate venue and methodology for ensuring global surgical services are accurately valued. If CMS believes that specific codes include postoperative visits that are not being performed, the agency should refer those codes to the RUC as potentially misvalued and request review rather than applying a broad policy to devalue all postoperative E/M services. However, evaluating all 10- and 90- day global codes is not acceptable, necessary or feasible and inappropriately singles out physicians performing surgery.

The RUC process, which is accepted and well understood by all surgical and medical specialties, ensures that every code is carefully evaluated for relativity by clinical and valuation experts and involves reviewing data from a statistically valid survey. CMS and the RUC, as collaborating partners, have used this process to identify potentially misvalued services, including the global service period. CMS and the RUC have identified potentially misvalued services related to global periods using, at first, the five-year review process and then the rolling RUC RAW process, which uses objective screens to identify procedures and services that are potentially misvalued, as well as the CMS public comment process.

In the last ten years, the RUC has reviewed 270 10- and 90- day global surgical codes, where the number of postoperative visits were verified. In fact, the RUC has reviewed, and CMS has finalized most high-volume services with the top allowed charges for 10-day and 90-day global services. All the services not reviewed generally have a very low volume. With cataract surgery as one example, we maintain that relying on the RUC and utilizing the potentially misvalued code process is the most accurate and efficient way to determine the frequency and level of the global code postoperative visits to establish overall global surgical code values.

To reiterate, ***CMS should increase the postoperative facility and office E/M services codes and the discharge management services codes in the global surgical codes, recognizing total time spent in the global surgical codes per the new E/M guidelines and the increased values to these codes. Otherwise, the relativity within the PFS is distorted. Finally, CMS should continue to collaborate with the RUC on a strategy for a global surgical code review process*** using objective screens to identify potentially misvalued global codes so that these services may be addressed without penalizing all surgeons and by using the RAND-proposed across-the-board devaluation of all global surgery codes. If CMS moves forward with a revaluation strategy, we stress that the agency should only utilize a clear, consistent, and proven methodology. CMS should not use one method, such as magnitude estimation for E/M codes, and then use a reverse building block methodology to reduce surgical services.

CONCLUSION

While MACRA requires CMS “to improve the accuracy of valuation of surgical services under the PFS,” the law does not mandate a wholesale revaluation of all 10- and 90-day global codes within the PFS. CMS should, therefore, use the RUC’s potentially misvalued procedures process to identify a targeted set of codes rather than any formulaic or flawed methodology applied to all global codes. The agency’s ongoing refusal to adjust the 10- and 90-day codes to reflect the incremental increases in the separately billable E/M codes amounts to an arbitrary, across-the-board cut for all surgical services — in contravention with the Medicare statute, which requires relativity across the PFS and outlaws specialty payment differentials. We, therefore, reiterate our request for CMS to proportionately increase all global surgery codes in the CY 2023 Medicare PFS to incorporate these E/M increases. Once adjusted, a thoughtful process in collaboration with the RUC can be utilized to ensure the accuracy of the global surgery code values. E/M codes included in global surgical packages need to be updated to reflect the concept of total time per the new guidelines as this would improve the accuracy of the valuation of surgical services,

recognizing this work that surgeons already perform within a 10 or 90-day global surgical package.

A well-functioning health care system requires access to surgical care, and as individuals live longer, Medicare must meet the needs of our patients. Undervaluing surgical care, as well as ongoing steep Medicare payment cuts, jeopardize timely access to quality care. CMS must, therefore, take the necessary steps to ensure fair reimbursement for all physicians so we can help our patients thrive in their golden years.

Thank you for considering our comments. We look forward to working with the agency to resolve this long-standing issue.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Obstetricians and Gynecologists
American College of Surgeons
American Orthopaedic Foot & Ankle Society
American Society for Metabolic and Bariatric Surgery
American Society for Surgery of the Hand
American Society of Cataract and Refractive Surgery
American Society of Colon & Rectal Surgeons
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urogynecologic Society
Congress of Neurological Surgeons
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons
The American Society of Breast Surgeons
The Society of Thoracic Surgeons

Attachment: Global Surgery Code Comments and Data Compendium

Global Surgery Comments

**A Compendium of Comments,
Recommendations and Data Analysis**



Prepared by the
Surgical Coalition

September 2022

Surgical Coalition Comments



Letters from a Coalition of National Surgical Societies



April 20, 2017

The Honorable Thomas Price, MD
Secretary
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: **Collecting Data on Resources Used in Furnishing Global Services**

Dear Secretary Price and Ms. Verma:

On behalf of the 23 undersigned organizations of the surgical coalition, we write to express concern with the implementation of the Centers for Medicare & Medicaid (CMS) policy requiring data collection on global services as finalized in the calendar year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule. Our organizations put the welfare of our surgical patients above all else, and we urge CMS to view policy changes through the lens of any potential impact on patients by focusing initially on the best care delivery models and then developing appropriate payment models to facilitate these care delivery models. We support policy changes that improve patient care and increase the accuracy of physician reimbursement, but CMS' data collection policy on global codes currently lacks sufficient information on its implementation and has already posed a serious barrier to the collection of accurate data.

Before data collection begins, we ask that CMS share a detailed plan for data validation, provide answers to outstanding questions, and assure providers that all claims submitted with the required data will be captured. **We do not think it is appropriate to begin the collection of data on July 1, 2017, before CMS has addressed these issues and provided adequate time for provider education.** If CMS continues with its plan to collect data even though it has not provided sufficient information in advance that allows for physician education and familiarity necessary to comply with the policy, the data will be inherently flawed and of low statistical quality. We strongly urge the Agency to avoid using such data to revalue global services starting in 2019.

Background – MACRA and the Medicare Physician Fee Schedule

Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to use rulemaking to obtain information needed to value surgical services from a representative sample of physicians, and it requires that the data collection begin no later than January 1, 2017. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery, as appropriate. Beginning in 2019, the information

collected, along with any other available data, must be used to improve the accuracy of the valuation of surgical services.

In the CY 2017 MPFS, CMS set forth a global codes data collection policy consisting of three components: (1) claims-based data reporting; (2) a survey of practitioners; and (3) data collection from accountable care organizations (ACOs). For claims-based reporting, CMS finalized a policy whereby practitioners who are in groups of 10 or more practitioners and who are located in any one of nine specified states would be required to report CPT code 99024 for every post-operative visit that they provide related to any CPT code on a list of 293 10- and 90-day global codes specified by CMS. This mandatory data collection begins July 1, 2017. Additionally, few details are known about the other two components, namely, the survey of practitioners and data collection from ACOs. Although MACRA allows a 5 percent withhold in payment for those practitioners who fail to report, we appreciate that CMS has not implemented this penalty.

Current Policy Implementation Hurdles

Claims-based data reporting of post-operative visits will be required starting July 1, 2017; however, **many aspects of this policy require clarification, making it difficult to educate the members of our organizations to prepare for a July 1 start date.** Some unanswered logistical and policy questions are described in the list below:

| Implementation Issues Regarding Claims-Based Reporting of Post-Operative Data |
|--|
| Definitions |
| <ul style="list-style-type: none"> The rule requires that practitioners in groups of 10 or more practitioners must report post-operative visits using 99024, but the term “practitioner” is not defined. This definition is needed in order for our members to determine whether they are required to report. |
| <ul style="list-style-type: none"> A “group” is defined not as practitioners sharing the same tax ID number (TIN) as in all other cases of CMS reporting, but rather those who share business or financial operations, clinical facilities, records, or personnel. This is a confusing definition of a group for the purposes of this policy. |
| Logistical/Readiness |
| <ul style="list-style-type: none"> Has CMS considered whether practitioners will be able to submit claims for 99024 for post-operative visits from any site of service? To collect an accurate number of the post-operative visits that are provided, practitioners must be able to report 99024 from all settings of care, not just ambulatory settings. |
| <ul style="list-style-type: none"> Are all CMS contractors prepared to accept 99024? |
| <ul style="list-style-type: none"> Who will educate clearinghouses and software vendors on the required 99024 reporting? We have heard anecdotally that some clearinghouses are rejecting 99024 claims. Our preliminary research has indicated that many clearinghouses have not been informed of this policy. |

| |
|---|
| <ul style="list-style-type: none"> If claims submission software or clearinghouses require that a monetary value be attached to 99024 codes (thereby preventing a claim from being rejected), would the CMS contractors have the capability of handling non-payable codes submitted with one penny attached? |
| <p>Submission of Claims</p> |
| <ul style="list-style-type: none"> If a practitioner sees the patient twice in one day should two 99024 codes be submitted for two visits? Or are practitioners limited to submitting one 99024 per 24 hour period? |
| <p>CMS Analysis of Data</p> |
| <ul style="list-style-type: none"> How will CMS keep the appropriate 99024 attached to the index procedure? This is especially important in cases where multiple CPT codes from the list of 293 codes are reported within the same global period. |
| <ul style="list-style-type: none"> Has CMS developed a method for providers to confirm that all 99024 codes have been captured? |
| <ul style="list-style-type: none"> How will CMS handle the data from practitioners who do not consistently report 99024? Despite best efforts at education, some practitioners will not reliably report 99024 as required. How will CMS take this into consideration? |
| <ul style="list-style-type: none"> How will CMS handle procedures that are submitted with modifiers? There are a number of modifiers that are appended to surgery claims that impact the provision of post-operative care and that could significantly impact data collection. |

We also have very little information regarding the survey of practitioners (the second component of global codes data collection). Some of the undersigned organizations have been contacted by the RAND Corporation (RAND) to nominate a member to be interviewed by RAND as it develops the survey. The CY 2017 MPFS final rule stated that the survey will be in the field by mid-2017, yet we do not know enough about the survey to begin educating our members on what to expect. In addition, it is critical that clinical experts from the specialties who will be surveyed have the opportunity to review and provide feedback on the survey design, methodology, content, and analysis. At this point, our understanding is that just one member of a selection of specialties will be interviewed and only those without payment expertise have been considered. We have many questions and concerns regarding the survey development and **we urge CMS not to move forward with this practitioner survey until it has been thoroughly vetted and the specialties to be surveyed have had an opportunity to review it and provide feedback.**

Even if CMS is able to collect useful data, which is of serious concern given the issues raised above, we do not believe that it is appropriate to use such data alone to improve the accuracy of 10- and 90-day global services. Despite possible CMS concerns regarding the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) process for valuing global codes, it is inappropriate to assign values to some CPT codes using a methodology that is completely independent from the RUC process. If CMS implements a valuation strategy outside of the RUC process, relativity

between CPT code values will be fundamentally disrupted, so **attempting to assign values outside of this relative value scale for some, but not all, CPT codes would be improper.**

Summary

We doubt that CMS will be able to achieve its intended goal to collect accurate and complete data that will improve the accuracy of global codes under this policy as it now stands. Given the significant implementation hurdles and the fact that there are less than three months before the mandatory claims-based data reporting is set to begin, **we do not believe it would be appropriate to begin the collection of data on July 1, 2017, unless CMS has addressed these issues raised by the undersigned organizations.** If CMS does move forward with its plan to collect data without providing enough information for adequate physician education, we recommend that the Agency not use flawed and misleading data to revalue global codes starting in 2019. Thank you for your consideration and your attention to this important issue for surgical patients and their physicians.

Sincerely,

**American College of Surgeons
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Osteopathic Surgeons
American Congress of Obstetricians and Gynecologists
American Osteopathic Academy of Orthopedics
American Society for Metabolic and Bariatric Surgery
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of Plastic Surgeons
American Urogynecologic Society
American Urological Association
Congress of Neurological Surgeons
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Gynecologic Oncologists
The American Society of Breast Surgeons
The Society of Thoracic Surgeons**

October 20, 2017

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Re: Global Surgical Services Survey

Dear Drs. Gidengil and Mulcahy:

On behalf of the undersigned 19 organizations, we are writing to voice our deep concerns with the Global Surgical Services Survey developed by RAND Corporation (RAND). Based on our review, we find this version of the survey fundamentally flawed as a means to collect useful information about the time, staff, and resources involved in furnishing postoperative visits and other services included in global surgical payment. We further detail the flaws in the survey below, but generally speaking, it is overly complex, time consuming, and difficult to complete. The survey should also be reorganized to make it easier for physicians to respond. In addition, specific questions must be rewritten to improve the structure and clarity of the questions. In additional areas, there must be complete deletions because questions include incorrect information or do not relate at all to the level of postoperative visits.

Use of the current survey will yield data that will make it impossible to accurately validate postoperative work values for specific procedures. **We urge RAND to suspend use of the survey in its current form; rather the survey should be revised to capture relevant information about postoperative visits using a format that is clear, straightforward, and logical. The survey should be directly related to capturing data on postoperative visits and should impose the least possible burden on the physicians in the survey sample.**

It is critical that clinical experts from the specialties who will be surveyed have the opportunity to provide feedback, so we appreciate that RAND has provided us an opportunity to preview this survey. In this letter, we provide feedback on various aspects of the survey, organized as follows:

- **Background**
- **Overall study design concerns**
 - Reporting on consecutive patients
 - Expected survey response rate
 - Length of survey

- Difficulty with completing the form
- Survey validation
- **Questions that should be reorganized**
 - Questions related to procedure codes and modifiers
 - Face-to-face and non-face-to-face questions
 - Questions related to work between or after visits
- **Confusing terminology and concerns with specific questions**
 - Confusing/incorrect terminology
 - Irrelevant questions to be deleted
 - Confusing/incorrect answer choices
 - Confusing/difficult to answer questions
- **Conclusion**

BACKGROUND

Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the Centers for Medicare & Medicaid Services (CMS) to use rulemaking to obtain information, starting January 1, 2017, from a representative sample of physicians to assess the accuracy of the valuation of surgical services. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery, as appropriate. Beginning in 2019, the information collected, along with any other available data, must be used to improve the accuracy of the valuation of surgical services.

In the calendar year (CY) 2017 Medicare Physician Fee Schedule final rule, CMS indicated that it planned to use a practitioner survey, in addition to claims-based data reporting, to comply with the MACRA requirement to collect data on global codes. The rule described a plan to sample practitioners, rather than specific procedures or visits, in an attempt to streamline survey data collection and minimize respondent burden. CMS stated in the final rule that the Agency expects a response rate in excess of 50 percent. CMS did not propose that respondents report on the entire period of postoperative care for individual patients, because the Agency considers a 90-day follow-up window (in cases of 90-day global codes) more burdensome to practitioners. Instead, CMS stated that it planned to collect information on a range of different postoperative services resulting from surgeries furnished by the in-sample practitioner prior to or during a fixed reporting period. CMS stated that the survey approach is intended to complement the claims data collection by collecting detailed information on the activities, time, intensity, and resources involved in delivering global services. The resulting visit-level survey data are intended to allow CMS to explore in detail the variation in activities, time, intensity, and resources associated with global services within and between physicians and procedures and are intended to validate the information gathered through claims.

OVERALL STUDY DESIGN CONCERNS

Reporting on consecutive patients

RAND indicates that a survey should be completed for every consecutive visit that is part of a 10- or 90-day global period (regardless of payer) until the physician reaches a total of 10 visit

surveys. The surveys will not be consecutive visits for the same patient following a specific procedure with a global period; rather, the survey will capture consecutive visits for different patients over the course of the physician's day (or days) until 10 visit surveys related to 10- or 90-day global codes are completed.

This survey design will not yield usable data for accurate valuation of individual CPT codes. As currently constructed, this approach will result in a broad range of responses with too few to draw reliable conclusions about the postoperative visits for any single CPT code. This is particularly true for those surgical specialties that perform a wide variety of procedures, such as general surgery. For example, a typical general surgeon regularly performs over one to two hundred 10- or 90-day global services. Thus, feedback from respondents will result in a jigsaw puzzle of data on disparate procedures from various points in the postoperative period, and it will be challenging to piece together an accurate picture of the range of services provided over the course of the postoperative visits for a given procedure. In other words, only a very large number of survey responses would produce statistically significant results for any one CPT code. However, based on the CY 2017 PFS final rule, CMS anticipates receiving approximately 5,000 responses from all postoperative visits on all codes from all specialties. It will not be appropriate to draw conclusions on how to revalue specific global codes from such a small sample size. **The current format that requires 10 surveys on consecutive visits is one of the most serious flaws of the Global Surgical Services Survey, and we urge RAND to reconsider this aspect of the survey design.**

Expected survey response rate

To expand on the points made above, much of the information that is being collected in the survey would need a very large number of responses to gather statistically significant data. The proposed rule indicates that approximately 9,000 practitioners (of all specialties) will receive a Global Surgical Services Survey, and that RAND expects approximately 5,000 responses. We believe that this is a gross overestimation of the expected response rate. For example, in the case of American Medical Association/Specialty Society Relative Value Update Scale Committee (RUC) surveys, which are far easier to complete, there is typically a response rate of less than 5 percent. In addition, neither CMS nor RAND have indicated what practice types will receive the survey. When determining the survey sample, we urge that RAND mirror national practice types (employed, academic, rural community, single, and multispecialty).

We are also concerned that a lack of education and/or dissemination of information about the survey process will further undermine the participation rate. In conversation, RAND has stated that physician education on the survey is not planned and that it is intended for physicians to receive and complete the survey without prior outreach. This strategy will make it even less likely that RAND will receive sufficient responses. **We consider the lack of education a serious design flaw and urge RAND to reconsider the number of surveys that will be sent out and the need for prior education.**

Length of survey

Another obstacle to the survey's success is its length and the time required to complete it. The introduction to the survey indicates that a physician is required to complete 10 surveys (one for each of 10 patients seen consecutively), in addition to providing practice information at the end of the 10 surveys. RAND estimates that the survey will take 10-15 minutes per patient with 8 minutes at the end for the practice information portion, for a total of 1.8 to 2.6 hours. **We have consulted with surgeons who have attempted to complete the draft survey, and it is clear that that the times offered by RAND are a gross underestimation of the amount of time it takes to complete the survey.** Specifically, it has taken our reviewers up to 30 minutes to enter the required information for **each** patient, in addition to 30 minutes to complete the practice information section. These surgeons understand the purpose of the survey and are experienced in coding and reimbursement. Those with no prior knowledge of the survey will likely take even longer. In addition to the inaccurate time estimates offered by RAND, physicians simply do not have this much time to complete the survey without planning to reschedule a lighter clinic load over one or more days. We cannot stress enough that the length and time required is much greater than RAND has suggested, and therefore will be one of the biggest barriers to physicians fully completing the survey. **The survey should be shortened and tailored to focus only on the information relevant to the level of postoperative visits, and should provide a more realistic estimate of the time required to complete so that physicians can plan accordingly.**

Difficulty with completing the form

As currently presented, it is difficult for physicians to enter information into the survey form. The survey format only allows one screen of the survey to be viewed at any given time. This "SurveyMonkey" approach can be appropriate for simple surveys where each question can be answered discretely. In contrast, the Global Surgical Services Survey is more complex and some early questions have bearing on later questions. For this type of survey it is extremely difficult to answer the questions without being able to view the survey as a whole. It is also cumbersome to complete the survey online when the computer that is being used for the survey also must be used to find information to complete the survey. This will require switching back and forth between screens to obtain some information. Our reviewers also had difficulty navigating between different questions within the survey to edit or verify that information was complete and consistent. For example, if some information is not readily available, the respondent should be able to skip ahead and fill out the information that is readily known. For these reasons, **it is critical that RAND provide the survey in a format that can be reviewed all at once, preferably as a multipage form similar to a Word document where scrolling up and down is allowed before submission. It is also imperative that RAND create a print function for the survey so the respondent has a record of what was submitted.**

Survey validation

We urge RAND to develop a methodology to validate the information that was provided by the survey respondents. Our reviewers were familiar with the information collection mandate, yet still found the survey questions poorly phrased and/or confusing. After completing the survey and after group discussion with RAND, our reviewers realized they had misinterpreted

some questions and provided incorrect responses. For example, one reviewer misunderstood that a survey was to be completed for each of 10 consecutive postoperative visit patients and instead provided information about the first postoperative visit for ten consecutive patients. Another reviewer included information on facility clinical staff services, despite the fact that facility staff are paid through facility fees and not through the physician's practice, and therefore would not be relevant to the valuation of global codes. **Without survey validation, there will be uncertainty as to whether the data and other observations drawn from the survey results will be accurate. We only support use of data that are demonstrated to be valid to assess the accuracy of resource inputs for global codes.**

QUESTIONS THAT SHOULD BE REORGANIZED

The order of survey questions and organization of some of the questions themselves are not coherent. Some of the requested information might be available in the patient medical record, and some information will need to be collected by other means, for example through the billing department or query of clinical staff. This creates a disjointed survey completion process where respondents will be required to stop midway through the survey because information is not readily available. Instead, the questions should be organized in a way that aligns with the availability of information and normal thought process for providing this information. Examples are provided below.

Questions on procedure codes and modifiers related to the visit

This question is included in the survey to collect information about procedure codes (and modifiers) related to the postoperative global code visit.

- ***“What was the procedure that prompted this visit? (Please enter a procedure with a 10- or 90-day global period. If multiple procedures prompted the visit, you will be given the opportunity to list these procedures later.)”***

First, procedures do not “prompt” postoperative visits; rather postoperative visits are related to procedures and services. Second, we recommend that the date of surgery be requested to confirm that the visit is within the global period for the procedure code(s). This is important because many surgeons, especially those that are new in practice or work in an employed environment may not know the global period of the procedures that they perform. Third, only two modifiers are allowed and anatomical modifiers are not allowed at all. We recommend that more modifiers, beyond just two, be allowed and that anatomical modifiers may be reported as well. Anatomical modifiers are relevant in cases where procedures can be reported in multiples, for example, repair of tendon in two fingers on one hand or one finger on both hands. In such cases, the postoperative visits would not be duplicated, but the work of dressing changes, therapy orders etc., will be greater at each visit for two hands versus one hand. **Disallowing anatomical modifiers would result in losing this information that is relevant to the services provided during the postoperative visit and causes us great concern as to why a survey that purports to seek data for accurate valuation of services would not be interested in capturing this information.** Fourth, the survey should request all of the CPT codes reported, not just the 10-

and 90-day global codes, to provide a more complete picture of the procedures and services provided during the operation.

We suggest that the questions related to dates and reported procedure codes/modifiers be reorganized as described in the box below so that the respondent will be able to accurately describe the relationship of procedures/services with postoperative work:

Please enter the date of surgery and all CPT codes(s) and modifier(s) that were submitted for payment for the operation that is related to this office visit.

Date of Surgery: <insert calendar selection tool>

CPT code 1: <insert CPT code dropdown box>

Modifier: <insert surgical modifier dropdown box>

Modifier: <insert surgical modifier dropdown box>

Modifier: <insert surgical modifier dropdown box>

CPT code 2: <insert CPT code dropdown box>

Modifier: <insert surgical modifier dropdown box>

Modifier: <insert surgical modifier dropdown box>

Modifier: <insert surgical modifier dropdown box>

CPT code 3: <insert CPT code dropdown box>

Modifier: <insert surgical modifier dropdown box>

Modifier: <insert surgical modifier dropdown box>

Modifier: <insert surgical modifier dropdown box>

CPT code 4: <insert CPT code dropdown box>

Modifier: <insert surgical modifier dropdown box>

Modifier: <insert surgical modifier dropdown box>

Modifier: <insert surgical modifier dropdown box>

CPT code 5: <insert CPT code dropdown box>

Modifier: <insert surgical modifier dropdown box>

Modifier: <insert surgical modifier dropdown box>

Modifier: <insert surgical modifier dropdown box>

Did you submit more than 5 CPT codes for the operation related to this postoperative visit?

Yes

No

Date of this postoperative <office / facility> visit: <insert calendar selection tool>

Please note that the surgical code(s) and modifier(s) related to the visit are not typically included in the patient's chart and may not be available on any screen that the physician can access on their office computer. Also, most surgeons may not have a solid grasp of modifiers that their practice billing departments may apply, even if they knew the one or two procedure codes that would apply. To complete these questions, the physician would be required to contact their practice manager or the practice billing department to request the procedure codes and modifiers submitted for payment. As such, the questions above should be moved to the beginning of the survey and should be allowed to be bypassed, if necessary, until the information is collected. This way the physician can complete the survey and then later obtain procedure codes and modifiers for all survey patients at once from their billing department, as needed.

In addition, for early postoperative visits, it is possible that the payment coding information may not be available if the claim has not yet been prepared for submission. It is also possible that one or more of the codes may be denied by the payer several months later, which is information the RAND survey will not be able to capture. Finally, it is possible that physicians will enter code and modifier information based on their perception of what should be reported and not confirm what was correctly reported or what was actually accepted by the payer. For these reasons, it will be difficult to collect procedure and modifier code information via this survey methodology, and any data that are collected will not be possible to verify.

Also, for this particular question, one of our reviewers attempted to add a 90-day code (60240, *Thyroidectomy, total or complete*) but the code did not appear in the drop down list of selections, so could not be added. If some but not all 10- and 90-day codes are able to be added as procedures related to the visit, then instructions should be included on how to handle procedures that are not found on the drop down list. If the intent of the survey is to allow all 10- and 90-day codes to be added as procedures related to the visit, then this lack of thoroughness should be corrected.

Face-to-face and non-face-to-face questions

The questions that address face-to-face (FTF) and non-face-to-face (non-FTF) activities and time are organized poorly in the current survey. There are several questions on this issue, but these questions should instead be combined into one question and placed on a single page and into one table. The example table below captures information from several of the survey questions, which should be combined into one request because reporting this information is part of a single thought process. **We urge RAND to revise the questions on FTF and non-FTF activities using this table as a guide:**

| | | You Personally (minutes) | Your NP/PA (minutes) | Your Resident (minutes) | Other Clinical Staff (minutes) | Not Performed |
|----------|------------------|-------------------------------------|---------------------------------|------------------------------------|---|----------------------|
| Activity | face-to-face | | | | | |
| | non-face to face | | | | | |

Work between or after visits

The following two questions are included in the survey to collect information about work performed between visits or after the survey visit:

- ***“Now we’d like to learn more about the work that sometimes takes place in between visits. Please select the activities below that you personally performed between the last time you or another practitioner in your practice saw this patient and this visit. Please do not include any activities performed on the day of this visit.”***
- ***“Based on your past experience, please select the non-face-to-face activities (which could include those done via phone or patient portal) that you personally expect to perform after this visit but before either the next anticipated visit or the end of global period (whichever comes first.) Please do not include any activities performed on the day of the visit of interest.”***

We are concerned that the survey implies that work “on the day of the visit” is completely distinct from work “between/after visits.” Every physician has his or her own personal approach to visit-related activities. Some physicians might perform certain activities on the day of the visit, while others might perform the same activities the day before or day after the visit. For example, an orthopedic surgeon may review a patient’s chart the day before the visit and add an order for an x-ray or an ophthalmologist may review a patient’s chart the day before the visit and add an order for an eye scan. In the offices where the review of the records or other activity is done “on the day” of the visit, these activities would be considered as non-FTF work. However, in cases where the work is done on the day before (i.e., between visits), it is considered different work, which is not clearly differentiated in this question.

Similarly, some post-visit work such as contacting another provider; work related to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); or home health orders can be done on the day of the office visit if time permits, or may be done the next day if, for example, the physician is called to another surgery. The mutually exclusive distinctions in the RAND survey assume that no work directly related to the survey visit was necessary “on the day of the visit” if it were not actually done that day. This is incorrect because the same work could be done on a different day.

An example of the lack of a clear bright line between what is considered work “between visits” versus what is considered work “after visits” is the review of lab results or images. These results/images can be reviewed three weeks before the current visit as post-work from the previous visit, but then reviewed again the day of the current visit as pre-work to the current visit. From a quality standpoint, the review in both instances is necessary to avoid a host of complications or inappropriate treatments. We do not understand the need for this distinction. The relevant questions are whether the work was done, who did the work, and how long the activity took. This is the information that the RAND survey should seek to collect.

Activities that are considered integral to the visit should encompass everything that is related to the visit, including all work before, during, and after, and should not be limited to the day of the visit. **RAND should revise the questions related to capturing work directly related to the survey visit versus work between or after visits that is not directly related to a visit, but still related to the procedure (e.g., phone calls from patient/family about a new symptom, communications with other providers).** There should be more clarity in the survey instructions as to how to understand and respond to these questions. **In addition, the survey should define “day” for the purposes of these and other questions.** It is not clear if “day” refers to the calendar day or a different 24-hour period surrounding the visit. The definition of “day” has different meanings between CMS and commercial insurance companies, so clarification is needed to accurately answer these survey questions. We also note that the question about work between visits only asks about the work of the physician or the physician’s partner, not other qualified health professionals or clinical staff. It is unclear whether lack of inclusion of work of clinical staff was intentional or an oversight. Given that clinical staff often provide some of the services between visits, we recommend including clinical staff in this question as well.

CONFUSING TERMINOLOGY AND CONCERNS WITH SPECIFIC QUESTIONS

Confusing/incorrect terminology

HCPCS codes versus CPT codes: Throughout the survey, questions include references to “HCPCS codes” instead of “CPT codes.” Although the survey notes that “*Level 1 HCPCS (Healthcare Common Procedural Coding System) codes are the same as CPT codes,*” HCPCS codes are not understood by surgeons and billers as procedure codes. It is possible that most physicians have never heard of HCPCS codes nor know what they represent. During office visits, in particular, if a surgeon has heard of HCPCS codes, they would think of them in the context of supplies such as casting materials, injectable drugs, etc. As such, “CPT codes” should be used throughout the survey instead of “HCPCS codes” because “CPT codes” are more recognizable to physicians.

Visit label: In an early question on the survey, there is a screen that requests the date of the visit and includes a box to add “Optional Visit Information,” which will be the “visit label” in the survey. When asked for clarification, RAND indicated that this is a way for physicians to label the visit to differentiate the 10 visit surveys from each other. This was not clear from reading the survey alone, so more clarification should be provided about the meaning of the “visit label” and how that term will be displayed throughout the survey.

CPT code short descriptors: The survey asks the physician to indicate an E/M code that would have been reported for the facility/office visit if the visit were not part of the global period. The survey notes that the “definitions” of E/M codes have been shortened due to constraints. CPT uses the term “descriptors” not “definitions,” so we ask that the RAND survey use the terms that are aligned with CPT. More importantly, the shortened descriptors are not correct and therefore add to the confusion of the survey.

For example, CPT code 99213 descriptor was shortened to:

Office/outpatient established patient, low complexity, low/moderate severity (15 min).

In contrast, the complete descriptor for CPT code 99213 states:

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

There are three key components to E/M code descriptors: history, exam, and medical decision making. FTF time can also be a factor if a majority of the FTF time is related to counseling and coordination of care. If RAND does not choose to include complete descriptors for this important question, then the shortened descriptions should be revised to accurately reflect the American Medical Association (AMA) CPT descriptions.

For example, CPT code 99213 could be shortened to:

Office visit, established patient, expanded problem focused history/exam, low complexity medical decision making, face-to-face is typically 15 minutes.

Irrelevant questions to be deleted

Several questions included in the survey are not relevant to assessing the work related to postoperative visits. Given that this survey is already long and time-consuming, we recommend deleting several questions. It is important that this survey be streamlined to focus on the goal of collecting relevant data on postoperative visits. That alone is a difficult task, and irrelevant questions make collecting accurate data more challenging. We recommend the following questions be deleted:

- ***“What is the primary payment source for the procedure(s)?”***
 - *Medicare or Medicare Advantage*
 - *Medicaid, CHIP, or other state-based program*
 - *Commercial*
 - *Other (including self-pay, TRICARE, VA, etc.)*
 - *Don't know*

This question does not relate to a physician's postoperative work and adds unnecessary time to the survey because the physician must find this information. Additionally, surgeons who are employed have little information on the insurance coverage of their patient. Also, in cases of emergent or urgent surgery, there is often not enough time for business office staff to gather, validate, and record the financial class of the patient. In such cases, it is not uncommon that the true insurance coverage of the patient is not determined for several weeks or months after the first encounter with the patient. Lastly, there is no evidence or suggestion from published studies that the insurance coverage of the patient has any bearing whatsoever on the level of postoperative visits.

- ***“Roughly, what percentage of your procedures is primarily paid for by each of the following sources?”***
 - *Medicare*
 - *Medicaid*
 - *Commercial insurance*
 - *Other (including self-pay, TRICARE, VA, etc.)*

This question does not relate to a physician’s postoperative work and adds unnecessary time to the survey for the physician to find this information. Many surgeons would consider this question intrusive on the physician’s private business matters. There is no evidence that this information has any bearing or impact on the level of postoperative visits for surgical patients.

- ***“What is the self-identified gender of the patient?”***
 - *Male*
 - *Female*
 - *Transgender*
 - *Does not identify as female, male, or transgender (non-binary/third gender)*

This question does not relate to a physician’s postoperative work and is inappropriate for the purposes of collecting data to determine the level of postoperative visit. We do agree, however, that the question about the patient’s age is appropriate to determine if the visit was related to a “typical” patient.

- ***“Where did this patient travel from to get to this office visit?”***
 - *Home*
 - *Another healthcare facility*
 - *Not known*
 - *Other*

This question does not relate to a physician’s postoperative work, rather it incorrectly implies that providing transportation is a physician or clinical staff activity. This question adds unnecessary time to the survey for the physician to obtain this information and has nothing to do with code valuation.

- ***“Was the scheduling of this visit expected as part of the typical post-operative course for the procedure(s) performed?”***
 - *Expected*
 - *Unexpected*

This question is ambiguous and will not result in usable data. The level of postoperative care for any given patient is dependent upon many variables including co-morbidities. Whether a visit was planned or unplanned has no impact on level of care delivered. It is also unclear as to whether an “expected” scheduled visit refers to a visit that is expected for the patient, expected for the physician, or expected by the institution as part of their overall institutional quality improvement program.

- ***“Was a complication from the procedure(s) performed addressed at this office visit? (Please note that we are not collecting data on complications – this is only to understand how complications might affect the time and resources related to postoperative office visits.)”***
 - *Yes*
 - *No*

The word “complication” with or without the parenthetical note can be misunderstood. A complication can sometimes be a common postoperative occurrence (e.g., seroma, anomalous pain, constipation) or an atypical occurrence (e.g., wound infection). Any of these occurrences would result in additional work at a postoperative visit. This question is ambiguous and also redundant because the information that the survey is trying to obtain is requested in other questions.

- ***“Which, if any, of the following staff assisted you on the day of this visit? Please do not include nurse practitioners (NPs), physician assistants (PAs) and other staff who are billing for this visit separately from you. If no staff assisted you, please select “None” below.”***
 - *Nurse Practitioner (NP)*
 - *Physician Assistant (PA)*
 - *Resident*
 - *Registered Nurse (RN)*
 - *Licensed Practical Nurse (LPN)*
 - *Medical/Technical Assistant (MTA)*
 - *Certified Surgical Technology (CST)*
 - *Other staff*
 - *None*

This question is redundant to all the subsequent questions that ask who provided face-to-face and non-face-to-face work.

- ***“For each of the following activities requiring supplies, please indicate who performed them on the day of this visit. These should be activities related to follow-up care for the procedure(s) that were the reason for this visit. If an activity was not performed, please select “Not performed” for that activity.”***

We believe this question is meant to capture information about supplies that are typically used during postoperative visits. It is included in both the office visit and the facility visit surveys, yet this question would not apply to facility visits. Supplies in the facility are reimbursed through a facility fee. This question is only relevant to the office visit survey because in the office the supplies are the burden of the physician. Supplies in the facility setting, however, are not included in the RVU reimbursement for physicians. As such, this question should be deleted from the facility visit survey.

In addition, there are a number of specialty-related supplies that are not included on this list. We ask that RAND either add more supplies to this list or create an “other” box for respondents to add more information on supplies. Additional supplies could include: Doppler, ultrasound,

seroma aspiration materials, drains, injectable saline or heparin to flush a catheter, or wound VAC materials. For a more complete list of all postoperative visit supplies, we refer RAND to the CMS practice expense detail files published in conjunction with the physician fee schedule proposed and final rules.

- ***“Did you or another practitioner in your practice last see the patient yesterday (i.e. the day prior to this visit)?”***
 - *Yes*
 - *No*

We do not understand the intent of this question. If the visit occurred in the facility, the answer would most likely be “yes” and if the visit occurred in the office the answer would most likely be “no.” Similar to our comments on other questions in this survey, this provides no new or usable information about the visit being surveyed. This question adds unnecessary time to the survey and should be deleted.

- ***“How much work was this visit compared to the typical post-operative visit that would occur at this point after this procedure?”***
 - *Much more work*
 - *Somewhat more work*
 - *About as much work*
 - *Somewhat less work*
 - *Much less work*

This question will not yield useful data unless you get a significant number of responses linked to the same postoperative visit for the same procedure or set of multiple procedures. This question requires the physician to consider, for example, the third postoperative office visit after a total colectomy for the survey patient compared to the third postoperative visit for all other total colectomy patients. The response to this question would only be useful if RAND received sufficient data points for the same CPT code, for the same numerical visit, and the same clinical scenario. The question about other reported procedures (i.e., multiple procedures) will provide a better sense of whether this was a typical postoperative visit, independent of whether it was the first, second, or third visit. Lastly, the thought process required to answer this question adds unnecessary time to the survey.

- ***“How much work was this visit for you personally, relative to a typical 99213 visit (office/outpatient established patient.....)? (Assume the work for a typical 99213 visit is 100%. A response of 50% indicates that this visit was half as much work as a typical 99213. A response of 200% indicates that this visit was twice as much work as a typical 99213.)”***
 - ____ %

This question follows another question where the survey respondent is asked to assign a CPT E/M code to the visit. If, for example, the respondent had stated in the prior question that the visit would be reported with 99213, we do not understand the purpose of asking the respondent to compare the survey visit to a typical 99213. This question adds confusion to the survey

because it could be interpreted that RAND is implying that there are easier 99213 visits and more difficult 99213 visits.

Confusing/incorrect answer choices

Several of the questions include answer choices that do not seem appropriate for the question or the context, or that do not seem to grasp the nuances of how surgeons practice. This has led to a great deal of confusion among our reviewers. Below are some examples:

- “Where did this visit take place?” (**office visit survey**)
 - Office
 - Hospital outpatient department
 - Other ambulatory setting

We recommend that instead of separating the survey into “office” and “facility” components, RAND should separate the survey into “office” and “all settings other than the office.” This would leave “facility” as any place of service other than an office, for the purposes of the Global Surgical Services Survey. RAND should then provide detailed information about settings early in the survey at the point when a physician makes the selection that leads to the rest of the survey being determined to be an “office visit.” We believe that most physicians will be able to discern the difference between office and everything else.

- “Where did this visit take place?” (**facility visit survey**)
 - Acute inpatient, non-ICU
 - Acute inpatient, ICU
 - Post-acute, long-term care facility inpatient, or skilled nursing facility
 - Emergency department
 - Ambulatory surgical center

These options are confusing because the reviewer is operating under the assumption that the visit for this survey was already determined to be an inpatient visit because it is describe as a “facility visit survey.” Emergency department and ambulatory surgical center visits would be coded as outpatient (but not office), so this question was confusing to our reviewers who were approaching the facility survey as intended to capture data strictly on inpatient postoperative visits within a global period. The survey instructions should include clear definitions for what constitutes a “facility visit” for the purposes of this survey. This information should be included early in the survey at the point when a physician makes the selection that then led to the rest of the survey being determined to be a “facility visit” survey.

Confusing/difficult to answer questions

A number of questions were not easily understandable or otherwise confusing to our practicing physician reviewers. Some questions do not reflect a nuanced understanding of how surgeons practice and make the assumption that most surgeons have detailed knowledge of the duties encompassed by the entire staff of an office, or the activities of the clinical staff related to patient

care when a patient is in the hospital. Some of questions ask for information that is not available or easily accessible by the physician completing the survey. Below are some examples:

- **Activities and time for staff on the day of the visit:** Our reviewers have concerns about the question regarding activities performed on the day of the visit and the staff who performed the activity. The question indicates that for each of the activities performed on the day of the visit, the survey respondent should also list who performed the activity, how long the activity took, and all of the resources used by these clinical staff.

This is a very difficult question for a physician to answer without consulting the medical record because the physician may not remember or be aware of all the activities that staff provided related to the visit or even be aware of all the clinical staff that provided activities, let alone the full list of resources. For example, clinical staff may have checked the patient in or out, taken vital signs, etc., without the physician knowing exactly who provided these services and/or what services were provided. In larger offices and clinics, the patient is checked in/registered in one location, then has a history, review of medications, vital signs, etc. in a second location, then is seen by the surgeon and other clinical staff in a third location within the clinic. Although this information would be documented in the medical record, it would not be information that the surgeon would be able to accurately report without referring to the record to finding all of the personnel that interfaced with a patient and then taking time to find out how long each activity took.

- **Staff time spent on visit:** A related question asks about the amount of time that the physician, NP/PA, resident, and other clinicians spent on the visit. Practices are busy with staff and patients moving around simultaneously. While services like these are documented, there has been no reason in the past to document the number of minutes dedicated to each service in this particular context and asking to retroactively report minutes associated with these services is an impossible ask certain to yield inaccurate data.

CONCLUSION

We stress that under the current Global Surgical Services Survey methodology it will be impossible to accurately determine postoperative work for specific procedures. For the reasons described above, we find this version of the survey fundamentally flawed as a means to collect useful information about the time, staff, and resources involved in furnishing postoperative visits and other services included in global surgical payment. We urge RAND to suspend use of the survey in its current form and to instead revise the survey to capture relevant information about postoperative visits using a format that is clear, straightforward, and logical. The survey should be directly related to capturing data on postoperative visits and should impose the least possible burden on the physicians in the survey sample.

Sincerely,

American College of Surgeons
American Academy of Ophthalmology
American Academy of Otolaryngology—Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Osteopathic Surgeons
American Congress of Obstetricians and Gynecologists
American Society of Anesthesiologists
American Society for Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society for Metabolic and Bariatric Surgery
American Society of Plastic Surgeons
American Society for Surgery of the Hand
American Urogynecologic Society
American Urological Association
Congress of Neurological Surgeons
Society of Gynecologic Oncology
The Society for Thoracic Surgeons
Society for Vascular Surgery

Cc: Kathy Bryant
Ryan Howe

August 15, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1715-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Policies for CY 2021 for Office/Outpatient E/M Visits in the CY 2020 Medicare Physician Fee Schedule Proposed Rule

Dear Administrator Verma:

On behalf of the undersigned 53 organizations, we write to voice our strong opposition to the Centers for Medicare & Medicaid Services' (CMS) proposal, as set forth in the calendar year (CY) 2020 Medicare Physician Fee Schedule proposed rule, not to incorporate into the global codes the adjusted values for the revised office/outpatient evaluation & management (E/M) codes. By failing to adopt all the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)-recommended work and time values for the revised office visit E/M codes for CY 2021, including the recommended adjustments to the 10- and 90-day global codes, CMS improperly proposes to implement these values in an arbitrary, piecemeal fashion.

It is inappropriate for CMS to move forward with the proposal to not apply the RUC-recommended changes to global codes. If CMS finalizes the proposal to adjust the office/outpatient E/M code values, the agency must apply these updated values to the global codes. It is imperative that CMS take this crucial step because to do otherwise will:

- ***Disrupt the relativity in the fee schedule:*** Applying the RUC-recommended E/M values to stand-alone E/Ms, but not to the E/Ms that are included in the global surgical package since the inception of the fee schedule, will result in disrupting the relativity between codes across the Medicare physician fee schedule. Changing the values for some E/M services, but not for others, disrupts this relativity, which was mandated by Congress, established in 1992, and refined over the past 27 years. Indeed, since the inception of the fee schedule, E/M codes have been revalued three times — in 1997 (after the first five-year review, in 2007 (after the third five-year review) and in 2011 (after CMS eliminated consult codes and moved work RVUs into the office visit codes). When the payments for new and established office visits were increased in these instances, CMS also increased the bundled payments for these post-operative visits in the global period.
- ***Create specialty differentials:*** Per the Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the “Secretary may not vary the . . . number of relative value units for a physicians’ service based on whether the physician furnishing

the service is a specialist or based on the type of specialty of the physician.”¹ Failing to adjust the global codes is tantamount to paying some doctors less for providing the same E/M services, in violation of the law.

- ***Run afoul of section 523(a) of MACRA:*** CMS points to the ongoing global code data collection effort as a reason for not applying the RUC-recommended changes to office visit E/M codes to global codes. In addition, the Agency states that it is required to update global code values based on objective data on all of the resources used to furnish the services included in the global package. These arguments conflate two separate issues. The issue that CMS raises regarding MACRA legislation is not related to maintaining relativity across the fee schedule based on current data in the CMS work/time file. In fact, section 523(a) specifically authorizes CMS to make adjustments to surgical services, notwithstanding the mandate to concomitantly undertake the MACRA-mandated global code data collection project.
- ***Ignore recommendations endorsed by nearly all medical specialties:*** The RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full increase of work and physician time for office visits be incorporated into the global periods for each CPT code with a global period of 10-day, 90-day and MMM (maternity). The RUC also recommended that the practice expense inputs should be modified for the office visits within the global periods.

Again, we strongly urge CMS not to finalize a policy that fails to apply the RUC-recommended changes to both stand-alone office visit E/M codes and the E/M component of the global codes. Our organizations will submit more detailed comment letters prior to the comment deadline, but the gravity of this particular proposal warrants an immediate response.

Thank you for your consideration of these comments, and we welcome continued dialogue with CMS on this critical issue.

Sincerely,

American College of Surgeons
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of PAs
American Academy of Physical Medicine and Rehabilitation
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Emergency Physicians

¹ 42 U.S. Code §1395w-4(c)(6).

American College of Mohs Surgery
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American Medical Association
American Orthopaedic Foot and Ankle Society
American Orthopaedic Society for Sports Medicine
American Pediatric Surgical Association
American Podiatric Medical Association
American Shoulder and Elbow Surgeons
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Cataract & Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of Dermatologic Surgery Association
American Society of General Surgeons
American Society of Metabolic and Bariatric Surgery
American Society of Plastic Surgeons
American Society of Retina Specialists
American Spinal Injury Association
American Urogynecologic Society
American Urological Association
Congress of Neurological Surgeons
Heart Rhythm Society
J. Robert Gladden Orthopaedic Society
Limb Lengthening and Reconstruction Society
Musculoskeletal Infection Society
Musculoskeletal Tumor Society
North American Spine Society
Orthopaedic Rehabilitation Association
Orthopaedic Trauma Association
Pediatric Orthopaedic Society of North America
Ruth Jackson Orthopaedic Society
Scoliosis Research Society
Society for Maternal-Fetal Medicine
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)
Society of Gynecologic Oncologists
The Hip Society
The Knee Society
The Society of Thoracic Surgeons

CC: Demetrios Kouzoukas, Principal Deputy Administrator for Medicare and Director, Center for Medicare
Carol Blackford, Director, Hospital and Ambulatory Policy Group
Gift Tee, Director, HAPG, Division of Practitioner Services

August 21, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1734-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Policies for Office/Outpatient E/M Visits in the CY 2021 Medicare Physician Fee Schedule Proposed Rule

Dear Administrator Verma:

On behalf of the undersigned 26 organizations, we write to voice our strong opposition to certain policies related to evaluation and management (E/M) codes in the calendar year (CY) 2021 Medicare physician fee schedule (PFS) proposed rule. The Centers for Medicare & Medicaid Services (CMS) is proposing to reduce the Medicare conversion factor from \$36.0896 to \$32.2605, or by 10.6 percent. This decrease lowers the 2021 conversion factor below the 1994 conversion factor of \$32.9050, which would be approximately \$58.02 today in current dollars.^{1,2} This extraordinary cut to the conversion factor is triggered by a number of proposed increases to the values of many bundled services that are comparable to or include office/outpatient E/M visits. The additional spending to support these increases along with the increases to stand-alone office/outpatient E/M visits totals \$10.2 billion.

In addition, CMS' failure to incorporate the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)-recommended work and time incremental increases for the revised office/outpatient visit E/M codes in the global codes is unacceptable, particularly in light of the adjustments proposed for other bundled services, such as the maternity codes. Organized medicine has been united in its recommendations that CMS incorporate the incremental revised office/outpatient E/M values in the global codes, as evidenced by the many comment letters and meetings over the past year. We are, therefore, deeply disappointed that CMS continues to ignore these recommendations in the CY 2021 Medicare PFS proposed rule.

The reduction of the conversion factor, paired with the failure to incorporate the revised office/outpatient E/M values in the global codes, will result in drastic cuts to many physician specialties. These cuts come at a time when specialists are struggling with the financial impact of the COVID-19 pandemic in many ways, including pay cuts from the suspension of elective surgery, salary reductions, furloughs, and layoffs.

¹ <https://www.ama-assn.org/system/files/2020-01/cf-history.pdf>

² https://www.bls.gov/data/inflation_calculator.htm. Using the U.S. Bureau of Labor Statistics inflation calculator, the conversion factor in 1994, \$32.9050, is worth approximately \$58.02 today. This means that the proposed CY 2021 cut of the conversion factor to \$32.2605 is an even steeper cut when adjusted for inflation and is by far the lowest conversion factor since its inception in 1992.

We reiterate that it is inappropriate for CMS to not apply the RUC-recommended changes to global codes starting in CY 2021. To do otherwise will:

- ***Disrupt the relativity in the fee schedule:*** Applying the RUC-recommended E/M value increases to stand-alone E/Ms, select global codes (e.g., monthly end-stage renal disease and bundled maternity care), and select bundled services (e.g., monthly psychiatric management), but not to the E/Ms that are included in the global surgical package will result in disrupting the relativity between codes across the Medicare PFS. Changing the values for some bundled services that include E/M services, but not for others, disrupts this relativity, which was mandated by Congress, established in 1992, and refined over the past 27 years.
- ***Create specialty differentials:*** Per the Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the “Secretary may not vary the . . . number of relative value units for a physicians’ service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.”³ Failing to adjust the global codes is tantamount to paying some doctors less for providing the same E/M services, in violation of the law. In the CY 2021 PFS proposed rule, CMS points to the method of valuation (i.e. building block vs. magnitude estimation) for a rationale as to why some bundled services should be increased in value to reflect the revised office/outpatient E/M values, while global codes should not. However, this statutory prohibition on paying physicians differently for the same work applies regardless of code valuation method and the incremental increases should apply to all physicians.
- ***Inappropriately rely on section 523(a) of MACRA:*** In the CY 2021 PFS proposed rule, CMS refers to its decision in the CY 2020 PFS final rule to not make changes to the valuation of the 10- and 90-day global surgical packages to reflect the increased values for the office/outpatient E/M visit codes while the agency continues to collect data on the number and level of post-operative visits included in global codes as required by MACRA. The MACRA data collection requirement, set forth in section 523(a), does not prohibit CMS from applying the RUC-recommended incremental increases to the office/outpatient E/Ms codes to global codes. In fact, section 523(a) specifically authorizes CMS to adjust surgical services, notwithstanding the mandate to concomitantly undertake the MACRA-mandated global code data collection project. In addition, it is inappropriate for CMS to rely on the implementation of MACRA, which passed in 2015, as a reason to refrain from making necessary updates in 2021. This inaction punishes a subset of physicians who, like all healthcare practitioners, are experiencing the pressures of a global pandemic.
- ***Ignore recommendations endorsed by nearly all medical specialties:*** The RUC, which represents the entire medical profession, voted overwhelmingly (27-1) in 2019 to recommend that the full incremental increase of work and physician time for office visits be incorporated into the global periods for each CPT code with a global period of 10-day, 90-day, and MMM (maternity). The RUC also recommended that the practice expense

³ 42 U.S. Code §1395w-4(c)(6).

inputs should be modified for the office visits within the global periods. In the CY 2021 PFS proposed rule, CMS is using the RUC recommendation as part of the rationale for proposing to increase the values of the maternity services codes and select other bundled services, but not the global bundled codes.

Again, we strongly urge CMS to apply the RUC-recommended changes to the E/M component of the global codes to maintain the relativity of the fee schedule. Our organizations will submit more detailed comment letters prior to the comment deadline, but the gravity of this particular proposal warrants an immediate response.

Thank you for your consideration of these comments, and we welcome continued dialogue with CMS on this critical issue.

Sincerely,

American College of Surgeons

American Academy of Facial Plastic and Reconstructive Surgery

American Association of Neurological Surgeons

American Association of Orthopaedic Surgeons

American College of Mohs Surgery

American College of Osteopathic Surgeons

American Glaucoma Society

American Orthopaedic Foot & Ankle Society

American Pediatric Surgical Association

American Society for Metabolic and Bariatric Surgery

American Society for Surgery of the Hand

American Society of Breast Surgeons

American Society of Cataract and Refractive Surgery

American Society of Colon and Rectal Surgeons

American Society of Ophthalmic Plastic & Reconstructive Surgery

American Society of Plastic Surgeons

American Society of Retina Specialists

American Urogynecologic Society

American Academy of Ophthalmology

Congress of Neurological Surgeons

Heart Rhythm Society

Society for Vascular Surgery

Society of American Gastrointestinal and Endoscopic Surgeons

Society of Gynecologic Oncology

Society of Surgical Oncology

The Society of Thoracic Surgeons

July 22, 2021

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1751-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Global Codes Policies in the CY 2022 Medicare Physician Fee Schedule Proposed Rule

Dear Administrator Brooks-LaSure:

On behalf of the undersigned 24 organizations, we write to voice our disappointment that the Centers for Medicare & Medicaid Services (CMS) has failed to incorporate the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)-recommended work and time incremental increases for the revised office/outpatient visit E/M codes into the global codes. CMS has failed to address this issue in both the calendar year (CY) 2021 and CY 2022 Medicare physician fee schedule (PFS) rules. While CMS did finalize adjustments for other bundled services, such as maternity codes, in the CY 2021 Medicare PFS rule, organized medicine has been united in its recommendations that CMS incorporate the incremental revised office/outpatient E/M values into all of the 10- and 90-day global surgical package codes, as evidenced by the many comment letters and meetings over the past several years. **We request a meeting with CMS to discuss this issue in more detail.**

The CY 2022 3.75 percent reduction of the conversion factor will further add to cuts that many physician specialties have been experiencing for years. **We reiterate that it is inappropriate for CMS not to apply the RUC-recommended changes to global codes.** To do otherwise will continue to:

- ***Disrupt the relativity in the fee schedule:*** Applying the RUC-recommended E/M value increases to stand-alone E/Ms, select global codes (e.g., monthly end-stage renal disease and bundled maternity care), and select bundled services (e.g., monthly psychiatric management), but not to the E/Ms that are included in the global surgical package will result in disrupting the relativity between codes across the Medicare PFS, which was mandated by Congress, established in 1992, and refined over the past 27 years.
- ***Create specialty differentials:*** Per the Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the “Secretary may not vary the . . . number of relative value units for a physician’s service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.”¹ Failing to adjust the global codes is tantamount to paying some doctors less for providing the same E/M services, in violation of the law. In the CY 2021 PFS proposed rule, CMS points to

¹ 42 U.S. Code §1395w-4(c)(6).

the method of valuation (i.e. building block vs. magnitude estimation) for a rationale as to why some bundled services should be increased in value to reflect the revised office/outpatient E/M values, while global codes should not. However, this statutory prohibition on paying physicians differently for the same work applies regardless of code valuation method and the incremental increases should apply to all physicians.

- ***Ignore recommendations endorsed by nearly all medical specialties:*** The RUC, which represents the entire medical profession, voted overwhelmingly (27-1) in 2019 to recommend that the full incremental increase of work and physician time for office visits be incorporated into the global periods for each CPT code with a global period of 10-day, 90-day, and MMM (maternity). The RUC also recommended that the practice expense inputs should be modified for the office visits within the global periods. In the CY 2021 PFS rule, CMS used the RUC recommendation as part of the rationale for proposing to increase the values of the maternity services codes and select other bundled services, but not the global bundled codes.

Again, we strongly urge CMS to apply the RUC-recommended changes to the E/M component of the global codes to maintain the relativity of the fee schedule congruent with the revaluation of the office and outpatient E/Ms. While we believe the Agency should have made the adjustments to the globals in CY 2021 rulemaking rather than in CY 2022, we would highlight that it would not be without precedent to address the valuation of the global codes in the subsequent year. After changes were made as part of the 1st Five Year Review of the PFS, CMS (then-Health Care Financing Administration (HCFA) initially declined to apply the E/M increases to the globals. However, the following year, in the CY 1998 PFS final rule, the Agency directly stated, “Upon further examination of this issue, we are increasing the work RVUs for global surgical services to be consistent with the 1997 increases in the work RVUs for evaluation and management services.”²

As we have consistently held, it has been the Agency’s policy to make these changes to the globals, and it would not be without precedent to make them in the year subsequent to the revaluation of the E/Ms. We implore the Agency to follow its own precedent and make this issue right.

Again, **we request a meeting to discuss this issue in more detail.** Thank you for your consideration of these comments, and we welcome continued dialogue with CMS on this and other critical issues.

Sincerely,

² Medicare: Physician Fee Schedule for Calendar Year 1998; Payment Policies and Relative Value Unit Adjustments and Clinical Psychologist Fee Schedule, 42 C.F.R. § 400 (1998).

American College of Surgeons
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology – Head & Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopedic Surgeons
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American Orthopaedic Foot & Ankle Society
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Society of Colon & Rectal Surgeons
American Society of General Surgeons
American Society for Metabolic and Bariatric Surgery
American Society of Plastic Surgeons
American Society of Retina Specialists
American Society for Surgery of the Hand
American Urogynecologic Society
American Urological Association
Congress of Neurological Surgeons
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Gynecologic Oncology
The Society of Thoracic Surgeons
Society for Vascular Surgery

October 28, 2021

Gift Tee

Director, Practitioner Services, Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS Meeting with Surgical Specialty Representatives on Global Codes Update

Dear Mr. Tee,

Thank you for the opportunity to meet on September 7, 2021, to discuss our concerns with the current Centers for Medicare & Medicaid Services (CMS) policy regarding the evaluation and management (E/M) post-operative office visits within global surgery codes. We remain strongly opposed to CMS' position not to incorporate the American Medical Association (AMA)/Specialty Society Relative Value Update Scale Committee (RUC)-recommended work and time incremental increases to the work relative value units (RVUs) for 10- and 90-day global codes commensurate with the increases to discrete E/M codes that were implemented on January 1, 2021. As we have mentioned in prior letters to CMS, this creates specialty work differentials, which is contrary to the Medicare statute. The current policy implies that physician work for an office visit is less when performed in a surgical global period. That is simply not correct.

There is a reason that the RUC and the house of medicine have advocated that the incremental RVU changes to E/M services be incorporated into the global codes: the work is equivalent. The level of work as required by the code descriptors involves the same medical decision-making for reporting. With the recent changes to the E/M descriptors and guidelines, this is even more evident. We have also described in previous letters that CMS has provided this equitable treatment to maintain relativity within the fee schedule in the past. The following is an expanded version of our comments, additional background on the valuation and coding of the global package, and responses to questions raised during the meeting.

Recap of Specialty Society Discussion Points

AMA RUC Review of 10- and 90-day Global Codes

The RUC employs an established and rigorous process for determining relative value units (RVUs) for procedures and services and is an appropriate venue for addressing global code values. As was mentioned during our September 7 meeting, many surgical services have been reviewed at the RUC for initial valuation or revaluation—including an assessment of the number and level of post-operative E/M visits. Since the passage of the Medicare Access and CHIP Reauthorization Act (MACRA), this process has been used to review 217 10- and 90-day global codes. CMS has accepted the recommendations for the number and level of post-operative office visits as accurate for all of these codes. This shows that CMS considers the RUC an effective process for evaluating potentially misvalued codes.

To maintain relativity, CMS should proportionately adjust the global codes to reflect the increased office E/M values. This will allow the RUC to continue updating and adjusting these codes as necessary with guidance and input from CMS and medical specialty societies to address potentially misvalued services. Without an adjustment to the global codes, the bedrock of relativity within the fee schedule is degraded, and future work by the RUC and CMS will progressively deviate from the established relative value of different physician services across the fee schedule in ways that are certain to compound imbalances to the resource-based relative value scale (RBRVS).

Past Precedent for Retroactively Adjusting Global Code Values

Adjustments to the global codes should have been made in calendar year (CY) 2021 rulemaking, but it would not be without precedent to address the valuation of the global codes in the subsequent year. After changes were made as part of the 1st Five Year Review of the Medicare physician fee schedule (PFS), CMS (then the Health Care Finance Administration) initially declined to apply the E/M increases to global codes. However, the following year, in the CY 1998 PFS final rule, the Agency stated, “Upon further examination of this issue, we are increasing the work RVUs for global surgical services to be consistent with the 1997 increases in the work RVUs for evaluation and management services.”¹

We also note that when the E/M codes were reviewed again during the 3rd Five Year Review of the PFS, the Agency agreed with the RUC and stated in the proposed rule for CY 2007: “We are in agreement with these RUC recommended work RVUs for E/M services. We also agree with the recommendation that the full increase for these codes should be incorporated into the surgical global periods for each Current Procedural Terminology (CPT) code with a global period of 010 and 090.”² In the final rule for CY 2007, commenters noted that the incremental increased proposed value might not have been accurate. The Agency responded that they would review the data sent by the RUC, and the correct incremental increases would be applied.

The following ophthalmology examples highlight the unintended consequences of this policy. These are just a few of the many examples of procedures erroneously impacted by the discrepancies in coding and relativity described above.

Ophthalmology Examples

- In CY 2019, the AMA RUC revalued cataract surgery CPT code 66984. The RUC survey found that in addition to a slight time change, ophthalmologists were providing three rather than four post-operative visits. This information was presented to the RUC, which made a revalued cataract code recommendation to CMS. CMS agreed and accepted the RUC-recommended value, which included three post-operative visits (one level-2 visit and two level-3 visits). Since CMS accepted the cataract surgery revaluation, it is clear that

¹ Medicare: Physician Fee Schedule for Calendar Year 1998; Payment Policies and Relative Value Unit Adjustments and Clinical Psychologist Fee Schedule, 42 C.F.R. § 400 (1998).

² Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology, 71 Fed. Reg. 37218 (June 29, 2006).

ophthalmologists should be paid at the same level E/M visit payments as other physicians providing standalone visits when they are providing the same level of service per patient.

- To highlight the inequity and illogic of this policy, consider the review of CPT codes 67141 and 67145 (*treatment of retinal breaks using cryo or laser to prevent retinal detachment*). The RUC recommended, and CMS accepted, work values of 2.53 RVUs for these codes, including two level-3 post-operative office visits in a 10-day global period. The 2022 physician work value of the two post-operative office visits alone would be 2.60 RVUs, greater than the work value of the procedure plus the post-operative office visits. This clearly demonstrates how a policy that does not apply incremental E/M increases to global codes disrupts relativity.
- Further, the societies considered valuing CPT codes 67141 and 67145 as 0-day global codes and billing post-operative visits separately when performed. However, both visits are necessary and typical within 10 days, making these codes a good fit for a global period and in harmony with other similar eye procedures. In addition, a 0-day global code would burden patients with additional out-of-pocket costs, requiring co-pays for both the procedure and each of the post-operative visits.

Background on the Valuation and Coding of the Global Package

Based on the discussion at the meeting with CMS, we provide the following additional background regarding “relativity” versus “equality” of the value of E/M codes in the global payment.

In 1990-1991, the Harvard Relative Value Scale Study assigned a relative “work” value for E/M post-operative visits included in a global package based on estimated physician face-to-face time multiplied by an intensity factor that was based on the then-current E/M codes. Harvard researchers established this intensity factor.

The CY 1990 proposed and final PFS rules included a total work value for some (high volume) global procedures reviewed in Phases I and II of the Harvard study, but not for E/M codes because these codes were undergoing revision at the CPT Editorial Panel. CMS staff and Harvard researchers were working separately with the CPT Editorial Panel to develop a new E/M code structure and descriptors, and Harvard was conducting surveys to value these codes for CY 1992.

When the PFS final rule for CY 1992 was published, the RVUs for the E/M codes were based on the 1991 Harvard Phase III surveys, but the time and RVU information for the E/Ms were never backfilled into the valuation of global codes.

For CY 1993, during a year-long refinement and after additional E/M review by Harvard in Phase IV, the values for the E/M codes were increased, and again these increased values were not backfilled into the global codes. This was not intentional. Rather, it was just a matter of the radical changes being made to physician payment in the United States at a time when computers were scarce, and technological capabilities of that era limited dissemination of data and information (i.e., desktop computers only had 1-2 gigabytes of memory).

In support of the information provided above, we point to the fact that Harvard assigned an intensity factor of 0.0224 to intra-service face-to-face E/M work in 1991 and applied this factor both to pre-service evaluation and positioning and to immediate post-operative time as equivalent to the intensity of discrete E/M work. However, by 1993, CMS increased the value of E/M codes using an intensity factor of 0.031 without calculating that same increased intensity into global codes. By then, all codes were based on RVUs and not on the Harvard “work” algorithm. Essentially, all global codes were shut out of the increased intensity only due to timing and not because of a difference in work.

Therefore, although CMS has applied the 1995 and 2005 E/M incremental increases and should apply the 2019 E/M incremental increases to maintain fee schedule relativity, the basis for E/M work in the global codes has never been fully incorporated. From the very beginning of the fee schedule, the global code post-operative E/M work relative value was discounted by 15-20 percent. But each time that E/Ms increased in value and CMS adjusted the global code values, only the incremental increase was applied, maintaining relativity. **In summary, since the inception of the fee schedule, the E/Ms in the global codes have been discounted, but relativity has always been maintained. By not applying the 2019 incremental increase, the Agency has essentially established two separate fee schedules that are no longer relative.**

Questions from CMS

Below, we provided detailed answers to questions asked by CMS during the September 7 call.

- 1. In the past, the point has been made that E/Ms that are bundled into global codes are different (valued more) for surgery, but now your point is that the E/Ms in global codes should be valued the same as the discrete E/Ms. Can you explain this difference?*

Response

This question highlights that although the work involved is the same for different kinds of E/M services, there are significant differences in practice expense (PE) and professional liability insurance (PLI) for discrete E/Ms and E/Ms bundled into global codes. Specifically, there is additional PE—clinical staff time, supplies, equipment, and equipment time inherent to post-operative office visits—for global codes. The American College of Surgeons (ACS) has argued that it would not be correct to convert a 90- or 10-day global code to a 0-day without the ability to capture the necessary post-operative PE that is above what is typically included with a discrete E/M service.

For some services, an E/M add-on code could provide the additional PE necessary for common procedures performed during a post-operative E/M. For example, an add-on code for suture/staple removal is currently being proposed to allow reporting of this post-operative work. In this instance, an add-on code that describes a procedure that will always be performed during an E/M visit allows separately reporting the appropriate level of E/M, which is not directly related to suture/staple removal. For example, the post-operative E/M could be provided after a simple repair of skin lacerations (straightforward medical decision-

making (MDM) visit) or after a 10-centimeter hernia repair for a patient who is having gastrointestinal functional issues and extreme pain (moderate/high MDM). In each case, the suture/staple removal is similar, but the MDM involved in the E/M service is different.

The issue of PLI and discrete E/M codes is still outstanding. The PLI RVUs inherent in 10- and 90-day global procedure codes are related to the PLI of the providers of the procedures—typically, these providers are surgeons. The PLI in discrete E/M services includes a significant percentage of providers with PLI rates that are much lower than that of surgeons. Therefore, when a surgeon performs a post-operative E/M service for a 0-day global procedure, the surgeon will never recoup their total PLI because the post-operative E/M PLI is diluted with lower PLI rates. The ACS has previously discussed this important issue with the Agency, but a solution has not yet been formulated.

In summary, the physician work to perform an E/M service is not different for any provider when reporting is based on MDM since each level of MDM is not specific to the provider’s specialty but instead is relevant to the patient presentation, data analyzed, and/or risk. On the other hand, the PE related to a post-operative E/M may involve additional clinical staff time, supplies and equipment for surgery. In addition, the PLI for surgeons is higher than the PLI in discrete E/M services that are provided a significant amount of time by providers with lower PLI rates.

2. *We recognize that it has been many years since MACRA was passed, and much work has been done. How do MACRA and the global code update impact services, patients, and providers?*

Response

First, Section 523 of MACRA explicitly calls for CMS to gather information needed to value surgical services and use these data to facilitate accurate valuation of surgical services. MACRA did not instruct revaluing all surgical services but instead directed the Secretary to collect data to enable accurate valuation. We believe the intent of the law has always been to enable accurate “relative” valuation. Also, surgical services involve more than just 10- and 90-day global codes. All 0-day global codes and some XXX global codes (e.g., fine needle aspiration, ventricular assist device implantation, extracorporeal membrane oxygenation) are surgical procedures.

From January 2014 through January 2020, the RUC reviewed 1,145 CPT and Healthcare Common Procedure Coding System (HCPCS) codes. Although the survey data median statistic for the typical patient supported an increased work RVUs (wRVUs) for many of these codes, the specialty-recommended wRVU was less than the survey median for 949 (83 percent) of the 1,145 codes and equal to the survey median for 179 (16 percent) of the 1,145 codes. The RUC took further action on the 1,145 specialty recommendations by decreasing 178 codes (16 percent) more than the specialty-recommended decrease. CMS took still further action by decreasing 274 codes (24 percent) more than the RUC-recommended decreases. Although the median statistic is intended to represent the typical patient estimate of work based on magnitude estimation and the Harvard study, 93 percent of the final CMS values were decreased to a wRVU that was less than the survey median. The median survey

wRVU was accepted for only 77 codes (7 percent) of the total 1,145 codes reviewed. We believe that the work required by MACRA to gather information to review and enable accurate relative valuation has been accomplished and will continue. CMS should acknowledge the impact of these extensive efforts to update and maintain relativity and should not hold the global code RVUs hostage to a misinterpretation of MACRA that all codes must be reviewed and changed at a single point in time or that relativity cannot be maintained until all codes are reviewed.

Second, the primary issue at stake is relativity. The Agency recognized the importance of maintaining relativity in the fee schedule after the RUC reviewed and recommended increases to discrete E/M codes and global codes after the 1995 and 2005 reviews. There is no reason not to implement the same action after the most recent review in 2019, given that numerous specialty societies have advocated for this for over two years.

Third, it is not and never will be feasible, or fair, to make a **universal change to the global period for thousands of unique services.**

We appreciate the opportunity to virtually meet with Agency leadership and staff regarding updating the global code RVUs commensurate with the increases to discrete E/M services. We reiterate that MACRA did not instruct a blanket revaluation of all surgical services but instead directed CMS to collect data to enable accurate valuation. We believe the intent of the law has always been to enable accurate relative valuation, and we believe that through the CMS and RUC processes of review, this has been and continues to be accomplished. **We urge CMS to adjust the E/M component of the global surgical codes in the final CY 2022 MPFS final rule to ensure relativity is maintained in the fee schedule.**

Thank you for your consideration, and we look forward to working with you on resolving this issue.

Sincerely,

American College of Surgeons
American Academy of Ophthalmology
American Association of Neurological Surgeons
American Society of Cataract and Refractive Surgery
Congress of Neurological Surgeons
The Society of Thoracic Surgeons

Congressional Comments



Letters from Members of Congress to CMS and Congressional Leadership



Congress of the United States
Washington, DC 20515

September 18 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner,

We are writing to express our concern regarding the provision contained in Centers for Medicare and Medicaid Services' (CMS) Physician Fee Schedule (PFS) proposed rule for calendar year (CY) 2015 to convert all 10- and 90-day global procedures to 0-day global procedures beginning in 2017.

We urge CMS not to finalize this proposal in the 2015 Physician Fee Schedule Final Rule and, instead, work with the surgical community and Congress on ways to address the concerns articulated in the proposed rule.

We believe that disrupting global surgical payments will be detrimental to beneficiary care, increase administrative burdens, and hinder the ongoing, systematic efforts to improve and coordinate the delivery of quality health care.

Global payments incentivize providers to coordinate care. We believe that supporting a coordinated, team approach to healthcare is the best way to ensure that patients receive the highest quality, and most efficient care. Without the global payment, we are concerned that surgeons will lose the ability to coordinate postoperative care for critically ill patients. Patients may also be less inclined to attend their follow-up appointments as a result of additional co-pays for each visit.

In addition to compromising individual patient care, eliminating the surgical global payment will limit the collection of patient outcomes information if patients elect to forgo follow-up or seek treatment from other health care providers. Obstructing the use of clinical data registries is a significant setback in the progress that has been made in disease tracking and quality improvement.

Further, current bipartisan, bicameral legislation to repeal and replace the flawed sustainable growth rate formula calls for a "period of stability" in physician pay to allow physicians to transition to alternative payment models. This proposal intends to introduce new complexities into an already flawed system and stymie that progress.

Finally, under CMS' proposal, each pre- and post-operative service will have to be coded and billed separately – increasing the administrative burden to surgeons and the cost to CMS for processing all of these additional claims. The American Medical Association estimates that the

elimination of the global period will result in 63 million additional claims filed to account for post-surgical evaluation and management services. Even if physicians could accommodate this enormous increase in volume, it is not clear that CMS would have the ability to process the information it is requesting.

We urge you not to finalize this proposal in the 2015 PFS Final Rule. Instead, we recommend that CMS work with Congress and the stakeholder community to develop other ways to address the concerns outlined by CMS in the proposed rule while facilitating the development of alternative payment models in the future.

Sincerely,



LARRY BUCSHON, M.D.
Member of Congress



PHIL ROE, M.D.
Member of Congress



BILL POSEY
Member of Congress



ANDY HARRIS, M.D.
Member of Congress



CHARLES BOUSTANY, M.D.
Member of Congress



LEE TERRY
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AMI BERA, M.D.
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TOM PRICE, M.D.
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MICHAEL BURGESS, M.D.
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PAUL BROWN, M.D.
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PATRICK MEEHAN
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DIANE BLACK
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RAUL RUIZ, M.D.
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PETER ROSKAM
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ANNE WAGNER
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BRAD WENSTRUP
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DAN BENISHEK, M.D.
Member of Congress



TODD YOUNG
Member of Congress



MARSHA BLACKBURN
Member of Congress



KYRSTEN SINEMA
Member of Congress



RON KIND
Member of Congress



JOE HECK, D.O.
Member of Congress



BILL JOHNSON
Member of Congress



BRETT GUTHRIE
Member of Congress

Congress of the United States
Washington, DC 20515

March 18, 2015

Speaker John Boehner
H-232, US Capitol

Minority Leader Nancy Pelosi
H-204, US Capitol

Dear Speaker Boehner and Leader Pelosi,

We are writing to express our concern regarding the provision contained in Centers for Medicare and Medicaid Services' (CMS) Physician Fee Schedule (PFS) final rule for calendar year (CY) 2015 to convert all 10- and 90-day global procedures to 0-day global procedures beginning in 2017. This change would dramatically increase administrative costs on physicians, taking away from patient care.

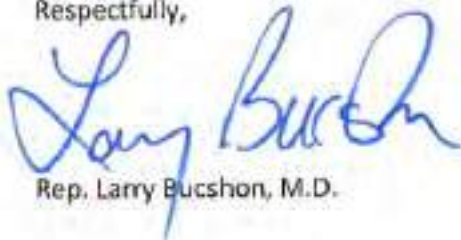
Global codes include necessary services normally furnished by a surgeon before, during, and after a surgical procedure. Global codes are classified as 0-day (typically endoscopies or some minor procedures), 10-day (typically other minor procedures with a 10-day post-operative period), or 90-day (typically major procedures with a 90-day post-operative period). Approximately 4,200 of the over 9,900 Current Procedural Terminology (CPT) codes are 10- or 90-day global codes.

Under the current global payment structure, patients typically pay one copay for the global bundled procedure and related follow-up care. If 10- and 90-day global codes are transitioned to 0-day global codes, patients will have a copay for the procedure and additional separate co-pays for other services, including each of the follow-up visits. This could considerably increase the financial burden on patients, or worse, discourage them from coming back for follow-up care. This would disproportionately affect the sickest patients who require more follow-up care than is currently bundled into global payment.

CMS must begin to transition all these codes no later than February 2016 in order to implement the change to 10-day global codes in 2017 and 90-day global codes in 2018, but CMS has not yet developed a methodology for making this transition. This transition is an incredibly large undertaking, since each pre- and post-operative service will have to be coded and billed separately – increasing the administrative burden to surgeons and the cost to CMS for processing all of these additional claims—an estimated 63 million additional claims filed. Not only would this be an enormous administrative cost to all physicians, taking away from patient care, but it is not clear that CMS would have the ability to process the information it is requesting.

We request language nullifying the global surgery period modification rule be included in any significant health care legislation receiving a floor vote.

Respectfully,


Rep. Larry Bucshon, M.D.


Rep. Ami Bera, M.D.

cc: Majority Leader Kevin McCarthy, Majority Whip Steve Scalise, Minority Whip Steny Hoyer



Rep. Andy Harris, M.D.



Rep. Phil Roe, M.D.



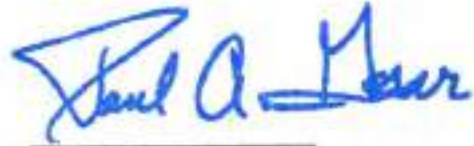
Rep. Brett Guthrie



Rep. Charles Boustany, Jr. M.D.



Rep. Bill Flores



Rep. Paul Gosar



Rep. Dan Benishek, M.D.



Rep. Marsha Blackburn



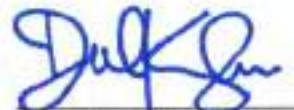
Rep. Chris Collins



Rep. Andy Barr



Rep. Ron Kind



Rep. Derek Kilmer


Rep. Raul Bartz, M.D.


Rep. Blake Farenthold


Rep. Brad Wenstrup


Rep. Tom Reed


Rep. Reid Ribble


Rep. Tom Rice


Rep. Kurt Schrader


Rep. Bill Johnson


Rep. Vern Buchanan


Rep. John Duncan, Jr.


Rep. Mike Kelly


Rep. Dave Loebsack


Rep. David McKinley


Rep. Ralph Abraham


Rep. Brian Babin


Rep. Yvette Clarke


Rep. Earl Blumenauer


Rep. Steve Cohen


Rep. Kyrsten Sinema


Rep. David Scott


Rep. C.A. Dutch Ruppersberger


Rep. Ed Whitfield


Rep. Will Hurd


Rep. Renee Ellmers


Rep. Mike Quigley


Rep. Scott Peters



Rep. John Fleming, M.D.


Rep. John Carney


Rep. Ann McLane Kuster


Rep. French Hill


Rep. Gus Bilirakis


Rep. Mo Brooks


Rep. Elizabeth Esty


Rep. Joe Courtney


Rep. Julia Brownley


Rep. Jackie Walorski


Rep. Brad Ashford


Rep. Ann Kirkpatrick


Rep. Jared Polis

Congress of the United States
Washington, DC 20515

September 16, 2016

Honorable Sylvia M. Burwell
Secretary
Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Mr. Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell and Acting Administrator Slavitt:

We are writing to express our opposition to the provision in the Centers for Medicare and Medicaid Services' (CMS) Physician Fee Schedule (PFS) proposed rule for calendar year (CY) 2017 to collect all data for all 10- and 90-day global services from all practitioners who perform these services, rather than from a "representative sample" of practitioners, which was required by The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Congress was united in opposition to the policy in the CY 2015 PFS final rule that would have transitioned all 10- and 90-day global codes to 0-day global codes beginning in 2017, because of concerns that the change would compromise patient care and significantly increase administrative burdens. Instead, Congress required CMS to collect data, starting January 1, 2017, on the number and level of visits furnished during the global period. Specifically, Section 523 of MACRA explicitly calls for CMS to gather information needed to value surgical services from a "representative sample" of physicians. Beginning in 2019, CMS must use these data to facilitate accurate valuation of surgical services.

We appreciate that CMS is not proposing at this time to implement the 5% withhold for services on which the practitioner is required to report, and we encourage CMS to maintain its proposal to avoid implementing the 5% withhold in the final rule. However, the CY 2017 PFS proposed rule disregards congressional mandate and requires any practitioners who furnish a procedure that is a 10- or 90-day global code report the pre- and post-operative services furnished on a claim using proposed "G-codes." The proposal will impose an undue administrative burden on the surgical community, disproportionately directing provider resources toward compliance and away from patient care. This burden will likely be compounded by other new reporting requirements from MACRA implementation, which is the most significant physician payment change in 25 years. Taken as a whole this has the potential to negatively impact both quality and access for patients.

We ask that CMS not implement this proposal in the final rule but instead include policy that reflects the law as passed to collect data from a "representative sample" that is the least-burdensome, yet adequate sample to yield statistically viable results.

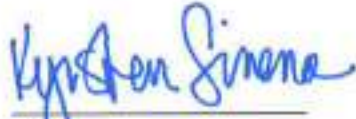
Sincerely,



Larry Burshon, M.D.
Member of Congress



Ami Bera, M.D.
Member of Congress



Kyrsten Sinema
Member of Congress



Tom Price, M.D.
Member of Congress



Andy Harris, M.D.
Member of Congress



Bill Flores
Member of Congress



Kenny Marchant
Member of Congress



David P. Roe, M.D.
Member of Congress



F. James Sensenbrenner, Jr.
Member of Congress



Mike Pompeo
Member of Congress



Dan Benishek, M.D.
Member of Congress



Ann Kirkpatrick
Member of Congress



Mo Brooks
Member of Congress



Brett Guthrie
Member of Congress



Michael C. Burgess, MD
Member of Congress



Marsha Blackburn
Member of Congress



Brian Babin
Member of Congress



Markwayne Mullin
Member of Congress



David McKinley, P.E.
Member of Congress



Brenda L. Lawrence
Member of Congress



Raul Ruiz
Member of Congress



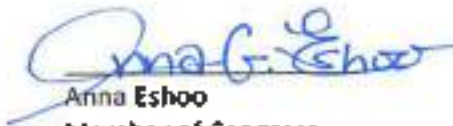
Tom Reed
Member of Congress



Bradley Byrne
Member of Congress



Robert J. Dold
Member of Congress



Anna Eshoo
Member of Congress



Pete Olson
Member of Congress



Tom Graves
Member of Congress



Lynn Jenkins
Member of Congress



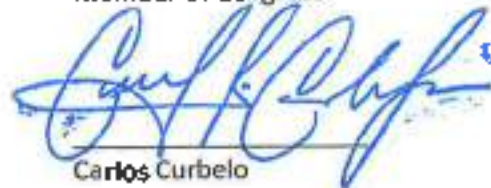
Brad Ashford
Member of Congress



Kristi Noem
Member of Congress



Gus M. Bilirakis
Member of Congress



Carlos Curbelo
Member of Congress



John J. Duncan, JR.
Member of Congress



Patrick J. Tiberi
Member of Congress



Chris Collins
Member of Congress



Joe Heck, D.O.
Member of Congress



Todd Rokita
Member of Congress



H. Morgan Griffith
Member of Congress



Julia Brownley
Member of Congress



David G. Valadao
Member of Congress



Mike Coffman
Member of Congress



Kurt Schrader
Member of Congress



Jason Smith
Member of Congress



Earl L. "Buddy" Carter
Member of Congress



Bill Johnson
Member of Congress



John Shimkus
Member of Congress



Pete Aguilar
Member of Congress



Matt Salmon
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Lou Barletta

Lou Barletta
Member of Congress

Bill Foster

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David Schweikert

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Richard Neal

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Dan Donovan

Dan Donovan
Member of Congress

Ron Kind

Ron Kind
Member of Congress

Susan Brooks

Susan Brooks
Member of Congress

Barbara Cornstock

Barbara Cornstock
Member of Congress

Kevin Yoder

Kevin Yoder
Member of Congress

James R. Langevin

James R. Langevin
Member of Congress

Ralph Abraham, M.D.

Ralph Abraham, M.D.
Member of Congress

Mike Thompson

Mike Thompson
Member of Congress

Rick W. Allen

Rick W. Allen
Member of Congress

Steve Israel

Steve Israel
Member of Congress

Adrian Smith

Adrian Smith
Member of Congress

Mike Kelly

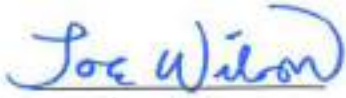
Mike Kelly
Member of Congress



Renee Elmers
Member of Congress



Jackie Walorski
Member of Congress



Joe Wilson
Member of Congress



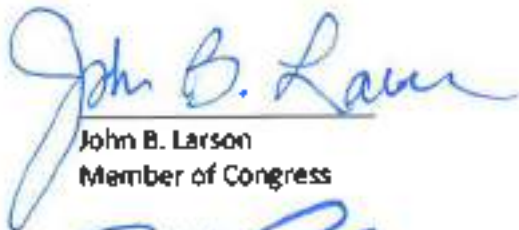
Robert Pittenger
Member of Congress



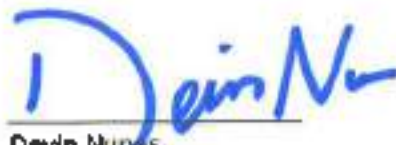
Steve Cohen
Member of Congress



Linda T. Sanchez
Member of Congress



John B. Larson
Member of Congress



Devin Nunes
Member of Congress



Adam Kinzinger
Member of Congress



Chris Van Hollen
Member of Congress



Todd Young
Member of Congress



Michael M. Honda
Member of Congress



Mark Walker
Member of Congress



Joe Crowley
Member of Congress



Garret Graves
Member of Congress



Peter Roskam
Member of Congress



Charles W. Boustany Jr., M.D.
Member of Congress



Erik Paulsen
Member of Congress



Pete Sessions
Member of Congress



Bill Pascrell, Jr.
Member of Congress



Sanford D. Bishop, Jr.
Member of Congress



David Joyce
Member of Congress



Reid Ribble
Member of Congress



Scott Garrett
Member of Congress



Diane Black
Member of Congress



Mia Love
Member of Congress



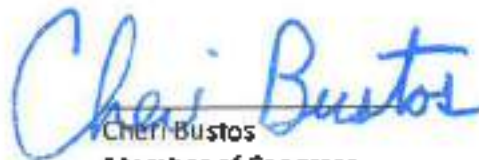
Charles W. Dent
Member of Congress



John Culberson
Member of Congress



Bill Huelskamp
Member of Congress



Cheri Bustos
Member of Congress



Robert E. Latta
Member of Congress



Joe Barton
Member of Congress

Ryan Costello

Ryan Costello
Member of Congress

Bill Posey

Bill Posey
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David Scott

David Scott
Member of Congress

Michelle Lujan Grisham

Michelle Lujan Grisham
Member of Congress

Gregg Harper

Gregg Harper
Member of Congress

Evan Jenkins

Evan Jenkins
Member of Congress

Jeff Duncan

Jeff Duncan
Member of Congress

Steve King

Steve King (IA)
Member of Congress

Dutch Ruppersberger

Dutch Ruppersberger
Member of Congress

Paul Gosar

Paul Gosar
Member of Congress

George Holding

George Holding
Member of Congress

Leonard Lance

Leonard Lance
Member of Congress

Billy Long

Billy Long
Member of Congress

Andy Barr

Andy Barr
Member of Congress

Rod Blum

Rod Blum
Member of Congress

Brad Wenstrup

Brad Wenstrup, D.P.M.
Member of Congress

Congress of the United States
Washington, DC 20515

September 27, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

We are writing to express our strong opposition to a provision in the 2020 Medicare Physician Fee Schedule proposed rule. Specifically, we are very concerned with the proposal to not include in the global codes the adjusted values for the revised office/outpatient evaluation and management (E/M) codes. We believe that CMS is arbitrarily implementing the E/M adjustments in a manner that runs counter to current law. Should CMS finalize its proposal to adjust the office/outpatient E/M code values, the agency must also apply these updated values to the global codes.

First, changing the values for some E/M services but not for others disrupts the relativity mandated by Congress as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239). Since the fee schedule was established, E/M codes have been revalued three times. Each time the payments for office/outpatient visits were increased, CMS also adjusted the bundled payments to account for the increased values of the E/M portion of the global codes.

Additionally, the Medicare statute specifically prohibits CMS from paying physicians differently for the same work, and the "Secretary may not vary the . . . number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician."¹ Failing to adjust the global codes as proposed is equivalent to paying some physicians less for providing the same E/M services.

Finally, through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10), Congress required CMS to collect data on the number and level of visits furnished in a global period. Although CMS may have concerns regarding applying the E/M changes to global codes while data collection is ongoing, as supporters of section 523(a) of MACRA, we believe nothing in the statute precludes CMS from making adjustments to surgical services before the collection is complete.

¹ 42 U.S. Code §1395w-4(c)(6).

We respectfully request that if CMS adjusts the office/outpatient E/M codes, then such adjustments should also be made to the E/M component of the global codes in order to maintain the relativity in the Medicare Physician Fee Schedule and to ensure that physicians are paid the same for providing equivalent services.

Thank you for your consideration, and we look forward to working with you on this issue.

Sincerely,



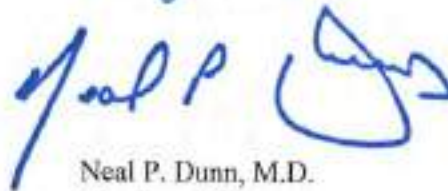
Ami Bera, M.D.
Member of Congress



Larry Bucshon, M.D.
Member of Congress



Brian Babin, D.D.S.
Member of Congress



Neal P. Dunn, M.D.
Member of Congress



A. Drew Ferguson, IV
Member of Congress



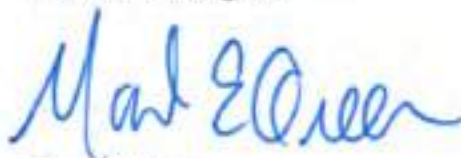
Brian K. Fitzpatrick
Member of Congress



Paul A. Gosar, D.D.S.
Member of Congress



Josh Gottheimer
Member of Congress



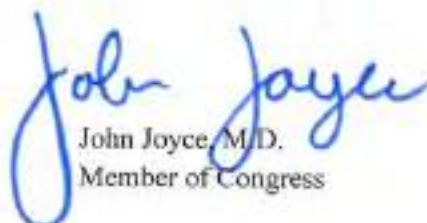
Mark E. Green
Member of Congress



Andy Harris, M.D.
Member of Congress



Kendra S. Horn
Member of Congress



John Joyce, M.D.
Member of Congress



Roger W. Marshall, M.D.
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Greg Murphy, M.D.
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Chris Pappas
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David P. Roe, M.D.
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Raul Ruiz, M.D.
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Kurt Schrader
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Kim Schrier, M.D.
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Michael K. Simpson
Member of Congress



Darren Soto
Member of Congress



Jefferson Van Drew
Member of Congress



Jackie Walorski
Member of Congress



Brad R. Wenstrup, D.P.M.
Member of Congress

United States Senate
WASHINGTON, DC 20510

October 30, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

We are writing to express our strong opposition to a provision in the 2020 Medicare Physician Fee Schedule proposed rule regarding the values of E/M office visits in global fee payments. Specifically, CMS proposes to increase the value of standalone E/M office visits beginning in 2021. However, the agency did not propose to increase the value of post-operative E/M visits that are bundled into 10- and 90-day global surgery codes. Arbitrarily adjusting some E/Ms but not others disrupts the relativity of the fee schedule and is in conflict with current law.

Increasing the values for some E/M services but not for others disrupts the relativity mandated by Congress as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239). Since the fee schedule was established, E/M codes have been revalued three times. Each time the payments for office/outpatient visits were increased, CMS also adjusted the bundled payments to account for the increased values of the E/M portion of the global codes.

Additionally, the Medicare statute specifically prohibits CMS from paying physicians differently for the same work, and the "Secretary may not vary the . . . number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician."¹ Failing to adjust the global codes as proposed is equivalent to paying some physicians less for providing the same E/M services.

Finally, through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10), Congress required CMS to collect data on the number and level of visits furnished in a global period. Although CMS may have concerns regarding applying the E/M changes to global codes while data collection is ongoing, as supporters of section 523(a) of MACRA, we believe nothing in the statute precludes CMS from adjusting surgical services before the collection is complete. If CMS believes that certain codes should be identified for further review of the number of post-operative visits, that should be a separate process under the misvalued code initiative.

¹ 42 U.S. Code §1395w-4(c)(6).

Therefore, we respectfully request that if CMS adjusts the office/outpatient E/M codes, then such adjustments should also be made to the E/M component of the global codes in order to maintain the relativity in the Medicare Physician Fee Schedule and to ensure that, as the law requires, physicians receive the same payment for the same services.

Thank you for your attention to this important issue.

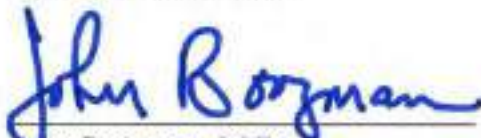
Sincerely,



Rand Paul, M.D.
United States Senator



John Barrasso, M.D.
United States Senator

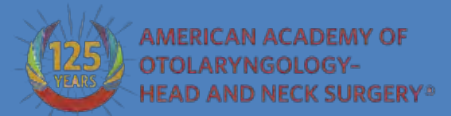
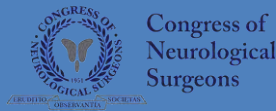


John Boozman, M.D.
United States Senator

Surgical Coalition Comments



Excerpts from National Surgical Societies' Comment Letters



AARP

Medicare Physician Fee Schedule 2015

"Potentially Misvalued Services: 10- and 90-Day Global Surgical Services

Under the umbrella of potentially misvalued services, the Centers for Medicare & Medicaid Services (CMS) is proposing to re-value 10- and 90-day global surgical services as 0-day global surgical services, meaning that any related evaluation and management services furnished on days other than the day of the procedure would be separately billable. There appear to be a number of uncertainties about exactly how this would be accomplished. Nonetheless, CMS proposes that the change would take effect in CY 2017 for 10-day global surgical services and in CY 2018 for 90-day global surgical services.

AARP finds this proposal somewhat surprising given other CMS efforts to bundle more services together, including through the various models currently being tested under the Bundled Payments for Care Improvement Initiative. The proposed unbundling appears to be in odd conflict with these other initiatives. More importantly from a beneficiary perspective, we are concerned that this unbundling could produce considerable confusion and cause beneficiaries to receive multiple explanations of Medicare benefits (and incur separate cost-sharing obligations) related to a single surgical procedure. In other words, we presume the new policy would lead physicians to file multiple claims, potentially including separate claims for individual post-operative visits, rather than a single claim for a global service. While we understand that the proposed unbundling could mean that the total cost-sharing obligation for many beneficiaries might be the same or less than under the current policy, in other cases, these cost-sharing obligations could be greater, as when beneficiaries require more than the typical amount of postoperative care. In any event, given the obvious methodological uncertainty and complexity involved in determining appropriate values for a very large number of “new” 0-day global services, and the likely confusion surrounding the resulting increase in Medicare claims, AARP has serious doubts regarding the benefit of this unbundling proposal. We suggest CMS consider other available alternatives, including the re-valuation of global services whose current values are believed to be incorrect.”

American Association of Neurological Surgeons Congress of Neurological Surgeons

Medicare Physician Fee Schedule (MPFS) 2015

“Improving the Valuation of the Global Surgical Package

Eliminating 10- and 90-Day Global Packages

The AANS and CNS oppose the elimination of the 10- and 90-day global packages and believe any attempt to finalize a schedule for such a plan is completely inappropriate. We believe the subject deserves far more review and discussion before implementation is contemplated. The unintended consequences are potentially much more far-reaching than were the major practice expense methodology changes imposed a few years ago, and those changes were a very long time in the making and involved years of stakeholder input. We believe the goal of ensuring that services with global periods are accurately valued can be achieved without completely overhauling the existing payment structure, which could lead to disaggregation and fragmentation of patient care and is completely contrary to current trends toward bundling. We fully support the comments submitted by the American College of Surgeons, generally agree with the comments submitted by the AMA RUC, and would highlight the following concerns:

- **Flaws in the OIG Reports.** To the extent the genesis of the CMS proposal to eliminate surgical global packages was the HHS Office of Inspector General (OIG) audits of evaluation and management (E/M) work in the global surgical period, we believe it is important to emphasize that the OIG reports are flawed in many ways. The number of claims for each individual service reviewed is low and the reports review the number, not the level, of visits. Of particular concern for neurosurgery is the fact that only one spine procedure was reviewed in the 2012 HHS OIG report on musculoskeletal procedures -- and that was dropped in the final analysis because of concerns about overlapping global periods for codes sometimes reported together. Global surgical services are based on the typical patient and any individual case could include more or fewer visits. We note the possibility that E/M work is under-reported in the patient record, precisely because the codes are not separately reportable. The issues of concern raised in the OIG reports do not justify completely abandoning the 10- and 90-day global surgical policy, which can be addressed through the RUC process and with improved education about the importance of accurately documenting that the visits have taken place.
- **Post-operative work not captured by E/M Codes.** In addition to visit services, there are many other post-operative care services included in 10- and 90-day global packages including dressing changes, local incision care, removal of operative packs, removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints, insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, and changes and removal of tracheostomy tubes.
- **Practice expense.** The PE for the E/M work in the surgical global package is more resource-intensive than separately-reported E/M services. E/M services performed following surgery often include additional, justifiably more expensive, supplies and equipment and may include additional clinical staff time relative to separately-billed E/M services. The RUC thoroughly evaluates the clinical staff time and the typical patient condition and type of services performed when recommending direct PE values. In addition, the indirect PE payment is dependent on specialty and is generally and appropriately higher for surgical specialists and this is reflected in the E/M visits included in the surgical packages.

- **Professional liability insurance expense.** The work RVUs of the proxy E/M services contained in the 10- and 90-day global packages are appropriately included in the professional liability insurance (PLI) expense calculation because the liability cost of a service should reflect the specialties performing it. Under the CMS proposal to eliminate global periods, E/M work would not be linked to the risk of the original service, would be diluted by the wide mix of all specialties performing E/M, and would not take into account the greater relative risk for the visits of a surgical patient.
- **Office visit level.** On average, global surgical packages have lower levels of office and hospital visits relative to separately-reported E/M visits. The median E/M visit in the global period is 99212, while the median separately-reportable office visit is above a 99213. The same is true for hospital visits. This is a factor that CMS should consider when assessing the impact of any proposal to unbundle visits.
- **Administrative burden.** The CMS proposal to eliminate global periods would create a huge and unnecessary burden for all stakeholders — patients, providers, and payors. Patients would be responsible for paying for each post-op visit separately, disadvantaging those who require more visits. Providers would be subjected to submitting additional claims and the Medicare Administrative Contractors (MACs) would have to process and pay them. In addition, there is no way to know how private payors would choose to treat global periods, creating potential confusion and processing delays.
- **Multiple surgery, bilateral surgery, co-surgeon policies.** Included among the many existing payment structures are those that reduce surgical bundled fees under certain circumstances in which multiple procedures or multiple physicians are involved in the care of the same patient. These policies are in place to account for overlap in resources, including those for E/M services. In addition, modifiers exist to account for a situation in which the post-op care is not provided by the operating surgeon, rarely if ever a situation for a neurosurgical patient.
- **RUC review of 10- and 90-day globals.** The RUC has begun to review 10- and 90-day global periods through the Relativity Assessment Workgroup (RAW). Recently, RUC-reviewed codes are clearer in terms of E/M work and we believe the RUC is the appropriate venue to address the valuation of the global surgical package. At the request of CMS, the RUC is in the process of examining high volume and high expenditure codes that have not been previously reviewed. We believe that this review by the RUC is the most effective method of addressing the issue. We maintain that improved education and RUC review of high expenditure codes that have not been previously reviewed will adequately address concerns about the appropriate valuation of global surgical services.

Global Surgical Package Comment Summary

The vast scope of the CMS proposal to eliminate global surgical packages presents significant disruption and disservice to all stakeholders. CMS is overburdened with numerous statutorily required work and we fervently believe that the wholesale dismantling of the 10- and 90-day global surgery bundle would neither result in savings to Medicare, nor would it be implemented in a way that would rationally justify its undertaking. The RUC has provided numerous suggestions for sources of outside data to consider in identifying issues of concern in the global packages. CMS can achieve its goals of more accurate valuation in the global surgical packages without forsaking a practice that emphasizes integration and continuity of care.”

“Overview of the Global Surgery Data Collection Proposal

CMS as proposed a three-pronged plan for collecting data on 10- and 90-day global surgery services.

- 1) **Prong One:** A “comprehensive claims-based reporting about the number and level of pre- and postoperative visits furnished for 10- and 90-day global services.” This will require all surgeons filing claims for 10- and 90-day global surgery services to report on the type and level of all visits included in the global period using a new G-codes system starting on Jan. 1, 2017.
- 2) **Prong Two:** A survey of a large, representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time, such as two weeks; and
- 3) **Prong Three:** A survey to collect primary data on the activities and resources involved in delivering services in and around surgical events in accountable care organizations. A small number of ACOs (Pioneer and Next Generation ACOs) will be surveyed.

Additionally, CMS is seeking comments on whether special provisions are needed to capture the pre- and post-operative services provided by residents in teaching settings. Finally, CMS notes that it does not at this time plan on implementing the 5 percent payment withhold to pressure physicians to comply with the global surgery data collection process. However, if CMS finds that surgeons are not complying with the required claims-based reporting, the agency will consider imposing up to a 5 percent payment withhold as authorized by the statute in a future rulemaking.

Our comments will focus primarily on the claims-based global surgery data collection effort, although we will provide the agency with several observations related to the other elements of the proposal.

Improving the Valuation of the Global Surgical Package

The AANS and CNS strongly supported section 523 of MACRA, which prevented CMS from eliminating the 10- and 90-day global periods (although we did not support the section granting CMS the authority to withhold 5 percent of physicians’ reimbursement to ensure compliance with this provision). We continue to believe that the goal of ensuring that global surgery services are accurately valued can be achieved without completely overhauling the existing coding structure. To do otherwise would lead to an administratively burdensome disaggregated system, that would result in fragmented patient care and is completely contrary to current trends toward bundling. Thus, we are committed to working with CMS to gather data on the 10- and 90-day global surgical package — in the least administratively burdensome manner — that will achieve the goal of accurately valuing these services.

Prong One: Claims-Based Pre- and Postoperative Data Collection Using New G-Codes

We are deeply discouraged by both the process and the results of the RAND report on the use of G-codes. Specifically, we are disappointed that a neurosurgeon was not included on the RAND technical panel. As a specialty that primarily provides surgical services reimbursed under the global surgical package, we believe this was a glaring and an unfortunate omission. Beyond who was invited to participate on the technical panel, the AANS and CNS believe the agency’s proposal is contrary to both the letter and intent of the Medicare Access and CHIP Reauthorization Act (MACRA), which directed CMS to gather data from a “representative sample of physicians” before making any changes to the global surgery package. Furthermore, while MACRA requires that a data collection process is in place by January 1, 2017, the G-code approach is an untested and flawed approach to collecting this information. At the very least, before implementing this data collection method, RAND should have

first conducted a valid pilot study with a limited number of physicians and codes. MACRA does not require CMS to launch the definitive study by January 1, 2017. Rather the agency must merely begin the “*process*” for evaluating 10- and 90-day global surgery services. We believe that a more rational approach to conducting this study should be employed, and working collaboratively with the physician community, CMS can meet its MACRA obligations.

G-Code Data Collection Burden

Both the AMA/Specialty Society Relative Value Scale Update Committee (RUC) and the American College of Surgeons (ACS) have demonstrated unacceptable burden of this proposal. The RUC estimates that the G-code data collection approach would generate nearly 500 million new claims. Assuming that each physician includes six codes per bill, this would result in an eye-popping 70-80 million additional Medicare claims. While CMS staff has indicated that their contractors are ready, previous large-scale rollouts of CMS programs make us skeptical. Even if CMS contractors can handle this enormous new number of claims, we believe most physicians and their practices cannot. The time and software requirements are simply not feasible.

The ACS communicated similar concerns to CMS when it recommended a more measured and reasonable timeline for data collection. The ACS recommended proceeding in stages, with the first stage only collecting the number and level of postoperative visits rather than for every 10-minute interval during the entire global surgical period. The rationale behind such a measured first step is that it would allow CMS to refine the data collection process to ensure accurate and valid data on physician work. The ACS made four additional recommendations:

- 1) The initial data collection should be from a sample of surgeons instead of all surgeons, as stated in the original MACRA legislation.
- 2) The initial data collection should come from a sample of codes with at least one postoperative visit and more than 10,000 claims or more than \$10 million in allowed charges.
- 3) Data submission should be easily adaptable for various software programs.
- 4) Adequate surgeon education should be precede implementation of the new coding process to promote surgeon participation.

We agree with these recommendations, and the data we have collected from a national survey of surgeons discussed below supports this phased approach.

G-Code Approach is Internally Flawed

Organized neurosurgery is very concerned that the details of the G-code system may render compliance difficult if not impossible for most practicing neurosurgeons. The proposed codes establish eight new codes that provide a means of reporting postoperative inpatient and outpatient evaluation and management (E&M) work, including phone and internet contact, and based on the duration of patient contact. While this is similar to the time-based reporting of some outpatient physician work, this approach does not easily generalize to postoperative patient care reporting.

As described in the thorough assessment of E&M coding provided by CPT, a variety factors comprise physician work. Our specialty does not routinely use time-based reporting of E&M work, using instead the more widely used CPT definitions for E&M coding. The physician work described by E&M coding is not just a function of time; there are many aspects of patient evaluation for which time is a poor measure: complex medical decision making, review of potential diagnoses, consideration of adverse event/complication occurrence, review of medical imaging, consideration of pertinent labs, discussion of complex cases with colleagues, etc. We believe that reliance on time as the primary metric of assessing physician work is flawed and reductionist.

The definitions of the G-codes are not clear in the proposed rule, specifically the difference between “typical” and “complex” inpatient and outpatient visits. Many neurosurgical patients are typically complex; thus, this pedestrian definition of the intensity of physician work will fail to capture the complexity of routine post-operative neurosurgical care. The descriptions offered in the proposed rule are simply inadequate. The documentation required for successful reporting is also not clear from our review of the text. What level of medical decision making is entailed in a typical patient encounter? What level of physical exam may be expected for a complex patient?

Most concerning, this approach requires an entirely different method to capture and code physician work. Most neurosurgeons code based upon accepted CPT terminology regarding patient history, examination, medical necessity, medical decision making and counseling. Instead, this new approach asks neurosurgeons to use a stopwatch to monitor their daily patient interactions. Hence, practicing surgeons will be required to both begin regularly and accurately reporting patient interactions that they are not capturing at present (in part because these services are not separately billable) and also to implement an entirely new coding methodology.

Adopting these changes — with both new processes to capture physician work provided during the global period and utilization of a whole new approach to E&M coding — will require considerable changes in practice, education of practitioners, and will consume significant physician and staff resources. As amplified below, we believe this G-code approach will produce flawed data and ultimately will not accurately reflect physician work.

Surgical Community Survey on Proposed G-Codes

The surgical community, representing more than 20 professional societies and approximately 250,000 surgeons and anesthesiologists in the United States, conducted a survey to gather information on the readiness and ability of surgeons to use the proposed G-codes to collect and report on services provided during the 10- and 90-day global surgery period. More than 7,000 physicians from across the spectrum of surgical specialties and reflecting a balanced geographic and practice type/size representation, responded.

The responses provided by nearly 300 neurosurgeons were consistent with the overall survey findings. Key highlights of the neurosurgical responses include:

| What do you anticipate will be required to integrate the new global surgery G-codes and data collection processes into your practice? | |
|--|-------------------|
| Answer Options | Response % |
| Developing new processes for tracking, collecting and distinguishing between pre- and post-operative visit information | 84.6% |
| Modifications to my electronic health record (EHR) and/or billing systems | 88.5% |
| Additional existing staff time to track and process pre- and post-operative visit information into the medical record and billing system | 76.7% |
| Hiring new staff members (billing, scribes, other) to track and process pre- and post-operative visit information into the medical record and billing system | 68.1% |
| Additional physician time spent on tracking pre- and post-operative visit information beyond that which is currently dedicated to documenting medical services | 91.8% |
| Purchase additional software to support and capture pre- and post-operative visits | 53.8% |

| | |
|---|-------|
| Increased number of claims submitted as well as significant new costs for the additional submission | 82.4% |
|---|-------|

What kind of processes do you anticipate will be required to comply with the new global surgery G-code data collection process?

| Answer Options | Response % |
|--|-------------------|
| Developing new pre- and post-operative visit tracking forms | 86.7% |
| Developing patient engagement and/or pre- and post-operative visit tracking forms | 73.7% |
| Developing a method for transferring pre- and post-operative visit data from one treatment site to another | 66.9% |
| Ability to differentiate Medicare patients in the pre- and post-operative settings so that G-codes are properly applied based on the patient's payer and data aggregated for this subset of patients in the practice | 88.8% |
| Hiring of scribes to shadow clinicians to document services | 50.4% |
| Use of handheld technology to document time spent providing pre- and post-operative services | 58.6% |

Approximately how much do you anticipate it will cost (including modifications to EHR/billing systems, staff costs, loss of productivity, etc.) to integrate the new global surgery G-codes into your practice in 2017?

| Answer Options | Response % |
|-----------------------|-------------------|
| \$0 to 10,000 | 2.2% |
| \$10,001 to \$25,000 | 7.2% |
| \$25,001 to \$50,000 | 13.7% |
| \$50,001 to \$75,000 | 11.5% |
| \$75,001 to \$100,000 | 14.7% |
| Over \$100,000 | 30.2% |
| Not sure | 26.2% |

Importantly, nearly 90 percent of neurosurgical respondents foresee physician compliance problems with the new global surgery G-codes and a super majority (78.1%) believe that the G-codes are an inappropriate method for measuring and accounting for physician services furnished during the 10- or 90-day global period. Finally, some common themes emerged from the open-ended comments we received about the data collection methodology. Samples include:

- *Leave as is. It is a global period. Each patient receives as much care in the postoperative period as required. Starting to track with these G -codes will kill efficiency and further discourage my treating Medicare patients. At the end of the day when I restrict how many Medicare patients I see because of these new burdens imposed by the government, the patients will suffer from decreased access. (Neurosurgeon employed by a hospital in a small, single specialty practice in the Midwest)*

- *Continue with current global period approach, since the simple and complex postop patients average out over time.* (Neurosurgeon from a medium-sized private, single specialty practice in the South)
- *Proposals such as this add extra hassle and risk for physicians providing for Medicare patients. The restrictions are so onerous, that it will encourage dishonesty just to complete the forms. People trying to honestly track every 10 minutes of time will quickly burn out. People will see less patients. Doctors with options are already realizing the vast majority of legal risk comes from Medicare/Medicaid patients. I foresee a time when good doctors decide that the risk is not worth the declining reimbursement. This type of soul-crushing intervention will simply encourage physicians to compete for non-government payers, and restrict access (or lose it altogether) for Medicare and Medicaid patients.* (Neurosurgeon from a large hybrid private/academic, multi-specialty practice in the Midwest)
- *Keep payments on a global basis as before because it does not place demand on surgeon's nonclinical/administrative time away from the care of the patient. Why would one debundle episodes of care for surgical treatment, when the trend is to pay for episodic management in healthcare?* (Neurosurgeon from a small hybrid private/academic, single specialty practice in the Midwest)

We urge you to consider this data carefully before launching the G-code data collection effort.

Specific Examples of Neurosurgeon Procedure Vignettes

While the survey provides CMS with a general overview of the unworkability of the G-code data collection method, the AANS and CNS also thought it would be beneficial for the agency to better appreciate the difficulty of applying these codes in the context of several typical neurosurgical procedures. As you will see, reporting pre- and postoperative care using a stopwatch in 10-minute increments is not feasible, does not reflect neurosurgical patient care and practice flow and will, therefore, likely yield unreliable results.

- **Neurosurgical Case Example #1 — Head Trauma.** An unrestrained automobile passenger with a severe closed head injury and an acute subdural hematoma due to an accident presents to the emergency department. The patient has multiple injuries, a Glasgow Coma Scale score of 5T, and is intubated. He is taken to surgery upon admission for a craniotomy to evacuate a subdural hematoma and place an extraventricular drain (EVD) (2 hours). The CPT codes for craniotomy for subdural hematoma evacuation and EVD are submitted. On postoperative day one, the patient is examined off sedation and computed tomography (CT) scans of the head are reviewed (30 minutes of surgeon time caring for the patient). Another 20 minutes is spent rounding on postoperative day two. That day, the patient's parents arrive, and the surgeon spends one hour with them discussing the severity of the injury, the surgical procedure, and the prognosis. The evening of postoperative day two, the surgeon responds to a series of calls over several hours regarding elevated intracranial pressure and spends 60 minutes reviewing CT scans and calling in orders. On postoperative day three, the intracranial pressure becomes refractory to exhaustive nonoperative measures. The surgeon decides to proceed with a decompressive hemicraniectomy (2 hours). The following day, the cycle of rounding (30 minutes) and family briefing (60 minutes) continues. On postoperative day five, the EVD stops working, and the surgeon replaces it (20 minutes). Over the first week, several hours (dozens of 10-minute intervals) are spent managing this patient. After four weeks in intensive care and two weeks in rehabilitation, the patient returns to the operating room for elective cranioplasty (2 hours). And this does not include any care rendered to the patient within the 90-day

global surgery period once he goes home but returns for follow-up visits to check on his recovery status.

This case illustration, which juxtaposes the G-code system with the current CPT system, is a typical scenario for any neurosurgeon on trauma call. The current global surgical period allows the neurosurgeon to submit four CPT codes and then focus on caring for the patient and communicating with the family, both of which have almost equal importance in these circumstances. With the new G-code system, the surgeon must submit four CPT codes and 40 or more G-codes when the entire intensive care unit stay is included. Every individual code will require additional supportive documentation. Each G-code will require surgeons to submit additional documentation to their compliance departments, which will expend an inordinate amount of time collecting documentation and reconciling it with G-codes before proceeding with submission.

Below is the current and proposed new tracking system coding required for this illustrative scenario for a **head trauma** patient:

| Day | Procedure/Service | Time | CPT Code | CPT coding w/G-codes |
|-----|---|--------|----------------|--------------------------|
| 0 | Craniotomy evacuation of subdural hematoma placement of EVD (separate site) | 3.0 h | 61312 61210 | 61312 61210 |
| 1 | Rounds, review of CT | 30 min | N/C* | GXXX3 × 3 units |
| 2 | Rounds, review of CT, flush EVD | 20 min | -- | GXXX3 × 2 units |
| 2 | Family meeting | 60 min | -- | GXXX2 × 6 units |
| 3 | Remote review of CT scan, management of ICP, replacement of EVD | 60 min | -- | GXXX7 × 3 units 61210 |
| 4 | Decompressive hemicraniectomy | 2 h | 61322 | 61322 |
| 5 | Rounds, review of CT, ICP management | 30 min | -- | GXXX2 × 3 units |
| 6 | Family meeting | 60 min | -- | GXXX2 × 6 units |
| 7 | Rounds, review CT, EVD management | 20 min | -- | GXXX2 × 2 units |
| 8 | Rounds, CT review, EVD management | 15 min | -- | GXXX2 × 2 units |
| 42 | Cranioplasty | 2 h | 61246 | 61246 |
| 43 | Rounds, CT review | 10 min | -- | GXXX1 × 1 unit |

* N/C indicates no reportable/billable code as service is provided within the 90-day global period.

- Neurosurgical Case Example #2 — Subarachnoid Hemorrhage w/Vasospasm and Hydrocephalus Requiring Shunt.** A 69 year old woman presents with temporary loss of consciousness and the worst headache of her life. CT of the head shows diffuse subarachnoid hemorrhage, and CT angiogram shows a wide-necked aneurysm of the left internal carotid artery at the origin of the posterior communicating artery. She is admitted to the ICU for stabilization, and the next day she is taken to the operating room for open surgical clipping of her aneurysm, as well as placement of an external ventricular drain (EVD) on the right to treat hydrocephalus noted on her imaging. On postoperative day one, the patient is examined, a CT scan with CTA is reviewed to ensure adequate treatment of the aneurysm as well as the hydrocephalus. (30 minutes). On postoperative day two, the patient has cerebral salt wasting and electrolyte management issues that require consultation with endocrinology (30 minutes spent rounding and communicating with the consulting teams). On postoperative day three, twenty minutes are spent rounding on the patient,

and in the evening the patient develops an episode of speech arrest and right arm twitching that resolves, thirty minutes spent speaking with ICU team, reviewing CT, and consulting neurology. (50 minutes) On postoperative day eight, the patient develops right hemiparesis, speech arrest and obtundation. She is intubated for airway protection. CT shows no hemorrhage, but CTA shows proximal middle cerebral artery (MCA) spasm; patient is taken to the angio suite for diagnostic angiography, left MCA angioplasty and injection of verapamil. On postoperative day 10, the patient becomes more lethargic and the CT now shows tiny hypodensities in both anterior cerebral artery (ACA) territories; patient is taken to the angio suite for diagnostic angiography and verapamil injection of bilateral ACAs. By postoperative day 14, the patient cannot be weaned from her EVD and a VP shunt is placed. On postop day 15 ten minutes are spent rounding on the patient and discussing issues related to discharge. On postoperative day 30, she is seen and her sutures are removed. On postoperative day 57, the patient develops fevers, nuchal rigidity, and a tap of her VP shunt reveals gram positive cocci; she is taken to the OR for VP shunt removal and EVD placement. She remains in the ICU for 11 days to ventricular drainage and antibiotic treatment. On postoperative 69 she returns to the OR for VP shunt replacement.

This case illustration, which juxtaposes the G-code system with the current CPT system, is a typical scenario for any neurosurgeon who treats ruptured aneurysms. The current global surgical period allows the neurosurgeon to submit 12 CPT codes relevant to the problems treated at the time of service (aneurysm clipping, vasospasm, hydrocephalus, shunt infection) and then focus on caring for the patient and communicating with the family, which is mission critical to patient and family centered care. With the new G-code system, the surgeon must submit 12 CPT codes and 72 or more G-codes when the entire intensive care unit stay is included. Every individual code will require additional supportive documentation. Each G-code will require surgeons to submit additional documentation to their compliance departments, which will expend an inordinate amount of time collecting documentation and reconciling it with G-codes before proceeding with submission.

Below is the current and proposed new tracking system coding required for this illustrative scenario for a **subarachnoid hemorrhage w/vasospasm** patient:

| Day | Procedure/Service | Time | CPT Code | CPT coding w/G-codes |
|-----|---|--------|-------------------------|--|
| -1 | Evaluation, review CT and CTA, discuss plan for surgery | 60 min | 99255 | 99255 |
| 0 | Left craniotomy for clipping of aneurysm, right frontal EVD placement | 6.0 h | 61697 61210 | 61697 61210 |
| 1 | Rounds, review of CT | 30 min | N/C* | GXXX3 × 3 units |
| 2 | Rounds, discussion with ICU & Endocrine teams | 30 min | -- | GXXX3 × 3 units |
| 3 | Rounds, initiate antiseizure treatment and EEG, neurology consultation | 50 min | -- | GXXX3 × 2 units GXXX7 × 3 units |
| 4 | Rounds, review Neurology recommendations | 30 min | -- | GXXX3 × 3 units |
| 5 | Rounds, EVD management | 30 min | -- | GXXX2 × 3 units |
| 6 | Rounds, review CT, EVD management | 30 min | -- | GXXX2 × 3 units |
| 7 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 8 | Rounds, CT review, angiography and treatment of left MCA spasm with angioplasty | 4 h | 61640 36224 36226 | 61640 36224 36226 GXXX3 × 6 units |

| Day | Procedure/Service | Time | CPT Code | CPT coding w/G-codes |
|-----|---|------------|--------------------------|---|
| 9 | Rounds, CT review | 45 minutes | -- | GXXX2 × 3 units |
| 10 | Rounds, CT review, angiography and treatment of bilateral ACA spasm with spasmolytic infusion, with exam after angiography and discussion with family | 5 h | 61650 +61651 36226 | 61650 +61651 +336226 GXXX3 × 6 units |
| 11 | Rounds, EVD management, review CT | 30 min | -- | GXXX3 × 3 unit |
| 12 | Rounds, EVD management | 30 min | -- | GXXX2 × 3 units |
| 13 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 14 | Rounds, VP shunt placement | 2 h | 62223 | 62223 GXXX2 × 2 units |
| 15 | Round, discharge | 15 min | | GXXX1 |
| 30 | Follow up visit, suture removal | 15 min | | GXXX5 |
| 57 | ED evaluation, shunt removal with EVD placement | 3 h | 62256 | 62256 GXXX3 × 3 unit |
| 58 | Rounds, EVD management | 30 min | -- | GXXX2 × 3 units |
| 59 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 60 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 61 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 62 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 63 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 64 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 65 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 66 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 67 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 68 | Rounds, EVD management | 20 min | -- | GXXX2 × 2 units |
| 69 | Rounds, EVD management, VP shunt replacement | 2 h | 62223 | 62223 GXXX2 × 2 units |
| 70 | Rounds, CT review | 20 min | -- | GXXX1 × 2 units |

* N/C indicates no reportable/billable code as service is provided within the 90-day global period.

- Neurosurgical Case Example #3 — Lumbar Spinal Fusion for Traumatic Fracture.** A 72 year old man is a passenger in a motor vehicle accident. On arrival in the emergency department (ED) he has severe back pain, and a CT of the lumbar spine reveals a traumatic fracture involving L1 with compression and instability. It is recommended that the patient undergo T11-L3 posterior instrumented fusion with decompression at L2. On postoperative day one, the patient is examined, post-op CT to evaluate hardware is reviewed, and the patient still has significant sanguineous drainage from drains placed at surgery (30 minutes). On postoperative day two, thirty minutes are spent examining the patient, removing the drains, coordinating with orthopedics (which is treating the patient's tibia-fibula fracture) and the trauma team (which is still evaluating the patient for a conservatively-managed splenic laceration). On postoperative day three, the patient is seen on

rounds and care is coordinated with orthopedics and physical therapy (20 minutes); later in the day the patient has an episode of desaturation while in bed. Thirty minutes are spent coordinating with the hospitalist on-call, who is evaluating the patient for possible pulmonary embolism (PE); anticoagulation management is discussed, and the chest CT is reviewed — which fortunately does not show a PE but rather atelectasis. On postoperative day four, the patient is seen on rounds with family now at the bedside; 40 minutes are spent discussing physical therapy, need for rehabilitation, and plans for long-term care. On postoperative day five, the patient is discharged to rehabilitation, but on postoperative day seven, the patient is brought back to the ED because of urinary retention. A CT scan is obtained in the ED, and thirty minutes are spent reviewing the images electronically, communicating with the ED about the possibility of cauda equina, and eventually the patient is admitted to Medicine for medication-related bladder atonia. On postoperative day eight the patient is seen and reassured, and sutures are removed at the bedside. (30 minutes) On postoperative day 30, the patient is seen in the office; he continues to wear his brace, but the family has multiple questions about whether the patient will be able to return to independent living or require long-term care because of persistent confusion, and a referral is made to neurology for evaluation of possible dementia along with scheduling of a head CT scan to rule out a delayed intracranial process (45 minutes). The head CT is reviewed the next day, and the family is called to relay the findings which are reassuring. (10 minutes) On postoperative day 60, the patient returns to clinic doing much better having been discharged from rehabilitation; spine x-rays are reviewed, and the patient’s brace is removed. The patient is seen on postoperative day 90, to assess his recovery, and he is doing well.

Below is the current and proposed new tracking system coding required for this illustrative scenario for a **lumbar spinal fusion for traumatic fracture** patient:

| Day | Procedure/Service | Time | CPT Code | CPT coding w/G-codes |
|-----|--|------------------|--|--|
| -1 | Evaluation, review CT, discuss plan for surgery | 45 min | 99254 | 99254 |
| 0 | T11-L3 posterior instrumented fusion with L2 decompression | 4.0 h | 22612 22614 × 3 63047 22842 20936 20930 | 22612 22614 × 3 63047 22842 20936 20930 |
| 1 | Rounds, review of CT and pain management | 30 min | N/C* | GXXX2 × 3 units |
| 2 | Rounds, remove drains, coordinate post-op care with Orthopedics and Trauma Surgery | 30 min | -- | GXXX2 × 3 units |
| 3 | Rounds, discuss therapy plans with Orthopedics and PT; Review CT chest, coordinate with hospitalist | 20 min 30 min | -- | GXXX2 × 2 units GXXX7 × 3 units |
| 4 | Rounds, family discussion | 40 min | -- | GXXX2 × 4 units |
| 5 | Rounds, discharge management | 20 min | -- | GXXX1 × 2 units |
| 7 | Discuss presentation with ED and hospitalist, review CT | 30 min | -- | GXXX7 × 3 units |
| 8 | Rounds, suture removal, reassure patient and family | 30 min | -- | GXXX2 × 3 units |

| Day | Procedure/Service | Time | CPT Code | CPT coding w/G-codes |
|-----|---|--------|----------|----------------------|
| 30 | Counsel patient and family; arrange neurology referral and order CT | 30 min | -- | GXXX6 × 3 units |
| 31 | Call patient and family about CT results | 15 min | -- | GXXX7 × 1 unit |
| 60 | Examine and counsel patient, review x-rays, remove brace | 30 min | -- | GXXX5 × 3 units |
| 90 | Examine and counsel patient | 20 min | -- | GXXX5 × 2 units |

* N/C indicates no reportable/billable code as service is provided within the 90-day global period.

These cases help to illustrate the real world difficulty that neurosurgeons and their staff would encounter when attempting to implement a G-code system. Imagine multiplying these numbers by an entire neurosurgery census. Over a week, the number of CPT codes skyrockets from 10-15 to several hundred G-codes, making it impossible to maintain accurate collection, documentation and submission without compromising patient care. The G-code system would distract every surgeon from their primary responsibility: the patient.

Alternative to G-Code Proposal

As stated above, the current G-code proposal will certainly fail because it is impossible to implement. At the very least, the effort will yield incomplete and unreliable results. If CMS insists on going this route, one year from now we will likely be in the same place; thus it makes sense to scale back the plan and adopt a more reasonable data collection and reporting process, such as those outlined in prongs two and three of the proposal.

If, however, CMS insists on proceeding with the claims-based data collection plan, the AANS and CNS would recommend that CMS build on existing mechanisms by using the RUC survey process and tracking postoperative visits using CPT Code 99024. This collaborative approach is well understood and could serve as the basis of an augmented data collection effort that would gather information from a representative sample of surgeons providing 10- and 90-day global surgery services. As the RUC has pointed out, it is important to consider the math regarding global surgical services and the likely low return on investment from requiring all physicians reporting these services to use the G-codes for every procedure. There are currently 4,239 CPT codes with global surgical packages in the Medicare physician fee schedule. According to 2015 Medicare utilization, there are only 110 10-day global and 149 90-day global codes performed more than 10,000 times. It, therefore, seems reasonable for CMS to identify a targeted subset of CPT codes that meet a minimum utilization threshold and from there identify an appropriate representative sample of physicians from whom to collect data.

We also encourage CMS to consider the RUC comments regarding the minimal variation among the level of office visits furnished in the global surgery packages. The median established office visit in a global surgical package is a 99212. Only one percent of all established patient office visits in 10- and 90-day global surgery packages have a visit level above 99213. The median hospital visit in a global surgical package is a 99231. Fifty-seven percent of hospital visits in a global surgery package have a hospital visit level of 99231.

Given these statistics, we agree with the RUC that data collection should be limited to a targeted subset of procedures. Furthermore, it is not necessary to distinguish the level of service in a claims collection process at all, as there is no identified problem to solve regarding the level of E&M bundled into the global surgical period. While we understand that MACRA requires CMS to obtain data on both the number and level of visits in the global surgical period, we nevertheless believe there is absolutely no need to require all physicians reporting 10- and 90-day global services to use the complex new G-

codes. Rather, CMS could use the existing 99024 code, which is readily available and incorporated in electronic health record and billing systems, and can be used to collect the number of visits. If necessary, data on the level of visits can be obtained through an additional RAND survey of practitioners.

Prong Two: Survey of Large Representative Sample of Physicians

The AANS and CNS support the agency's plan to conduct a survey of a large, representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified period, such as two weeks. In fact, given that CMS plans to conduct such a study, we simply do not understand why the agency is even considering the claims-based G-code proposal. Moving forward with the survey outlined in prong two survey would allow CMS to meet the statutory requirements of collecting data from a representative sample of physicians and would certainly be the least disruptive approach. Should the data obtained from this method be insufficient, CMS, working in collaboration with the physician community, can consider additional strategies.

Prong Three: Accountable Care Organizations (ACOs) Data Collection

CMS has proposed collecting primary data on the activities and resources involved in delivering services in and around surgical events in an ACO by surveying a small number of ACOs. While the AANS and CNS are not opposed to this effort, we do want to caution against CMS extrapolating information gathered from ACOs to value global surgery services that are provided outside of the ACO setting. ACOs are structured differently than other practice settings and data from ACOs may, therefore, be skewed. Furthermore, we note that ACO participants typically are larger practices and thus would underrepresent smaller or solo practitioners.

Special Requirement for Teaching Hospitals

CMS has asked for comments on whether special provisions are needed to capture the pre- and postoperative services provided by residents. To this end, the agency has recommended that any practitioner who provides services as part of the global surgery package use the proposed G-codes, including services rendered by residents. The AANS and CNS likewise object to the G-code method for collecting global surgery data in teaching hospital settings. We would expect that if CMS includes academic medical practices in their representative sample, the agency would be able to obtain information on the services provided by residents under the direct supervision of attending surgeons. Therefore, a "special" rule for physicians at teaching hospitals is completely unnecessary. We hope we have left no doubt about our opposition to the use of the G-codes, and, as such, the AANS and CNS can unequivocally state that we do not believe surgical residents should be required to report the codes.

Timeline for Implementation

There is simply not adequate time to educate providers on a new system of reporting by January 1, 2017, especially if CMS goes forward with the prong one proposed plan to roll-out a claims-based data collection methodology using a complicated system of new G-codes. The AANS and CNS interpret MACRA to require CMS to have a "process" in place to gather data from a representative sample of practitioners by January 1, 2017, but the law does not define the details of this process. The agency can easily meet this statutory requirement by implementing prongs two and three of the planned data collection program. Subsequently, if necessary, CMS can revisit a claims-based system or other more option such as using CPT Code 99024 and an enhanced RUC survey process. Again, this phased approach will ensure that the agency meets its MACRA mandate in a way that is least burdensome for physicians and the agency.

Payment Withhold

The AANS and CNS appreciate and support the agency's decision not to implement a 5 percent withhold to improve compliance with data collection. We believe this withhold is unnecessary and would be counterproductive to CMS' effort to obtain physician cooperation. We are confident that a collaborative approach with organized medicine will allow CMS to get valid information that the agency can then use to ensure the accuracy of the value of 10- and 90-day global surgical packages.

CONCLUSION

The AANS and CNS appreciate the opportunity to comment on the agency's plan to collect data on 10- and 90-day global surgery services. We commend CMS for refraining from implementing a 5 percent payment withhold to enhance physician compliance with this data collection effort. However, we unequivocally oppose the proposal to require all physicians who report 10- and 90-day services to use new G-codes for all services provided within the global surgery period. Rolling out this colossal unfunded administrative burden — which is of questionable value — at the same time physicians are implementing MACRA's new Quality Payment Program, is unnecessary and unlikely to produce useable information. Expecting physicians to learn the reporting requirements for these new codes and to have software and other infrastructure in place to report them with only eight weeks of notice before CMS flips the switch on January 1, 2017, is just unreasonable.

We hope that the agency will employ a more collaborative approach for obtaining data on services provided in the 10- and 90-day global surgical packages and the AANS and CNS are willing to participate in such efforts through the RUC or other venues.”

MPFS 2018

“Global Surgery Data Collection Project

The Medicare Access and CHIP Reauthorization (MACRA) Act (Pub.L. 114-10, Section 523) requires the Centers for Medicare & Medicaid Services (CMS) to collect information on the number and level of medical visits furnished during the 10- and 90-day global surgery period from a “representative sample” of physicians and in 2019 use this information to improve/validate the accuracy of the valuation of surgical services.

In the CY 2017 Medicare Physician Fee Schedule (PFS), CMS set forth a global codes data collection policy consisting of three components: (1) claims-based data reporting; (2) a survey of practitioners; and (3) data collection from accountable care organizations (ACOs). For claims-based reporting, CMS finalized a policy whereby practitioners who are in groups of 10 or more practitioners and who are located in any one of nine specified states — Florida, Kentucky, Louisiana, New Jersey, Nevada, North Dakota, Ohio, Oregon and Rhode Island — are required to report CPT code 99024 for every post-operative visit that they provide related to any CPT code on a list of 293 10- and 90-day global codes (30 of which are services provided by neurosurgeons) specified by CMS. Additionally, few details are known about the other two components, namely, the survey of practitioners and data collection from ACOs.

CMS began the implementation of this onerous data collection process on July 1, 2017, despite the fact that the agency has failed to (1) provide a detailed plan for data validation; (2) provide answers to a whole host of outstanding questions; (3) assure physicians that claims submitted with the required data will be captured; and (4) adequately educate physicians subject to the data collection requirements.

The AANS and CNS have recommended that Congress repeal Section 523 of the Medicare Access and CHIP Reauthorization Act (MACRA) as it is unnecessary. CMS already has in place a process for reviewing and adjusting the value of surgical services. Irrespective of Congressional action, **we urge CMS to delay the global surgery data collection project — both claims data and the provider survey — until CMS has addressed outstanding project issues and conducted adequate provider education.** Additionally, **the agency should avoid using any data collected in 2017 to revalue global services in 2019, particularly until the validity of such data can be ascertained.** Furthermore, **CMS should suspend the practitioner survey until it has been thoroughly vetted and the specialties to be surveyed have had an opportunity to review it and provide feedback.** Finally, if CMS can collect useful data (which we doubt), **the agency should refrain from modifying values for those CPT codes subject to data collection outside of the well-established American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) process.”**

MPFS 2019

“Global Surgery Data Collection Project

The Medicare Access and CHIP Reauthorization (MACRA) Act (Pub.L. 114-10, Section 523) requires the CMS to collect information on the number and level of medical visits furnished during the 10- and 90-day global surgery period from a “representative sample” of physicians and in 2019 use this information to improve/validate the accuracy of the valuation of surgical services. CMS began the implementation of this onerous data collection process on July 1, 2017, despite the fact that the agency has failed to (1) provide a detailed plan for data validation; (2) provide answers to a whole host of outstanding questions; and (3) adequately educate physicians subject to the data collection requirements. Therefore, we are not at all surprised that CMS has found that the data collected is not actionable.

The AANS and CNS have long believed that Section 523 of the Medicare Access and CHIP Reauthorization Act (MACRA) was inadvisable and unnecessary, as CMS already has in place a process for reviewing and adjusting the value of surgical services with input from the RUC. Nevertheless, we understand that MACRA required the collection of data and CMS has collected data. We believe that the agency’s data collection project has met the requirements of the statute, even though the data collected are not useful or valid for making any changes in the global surgery services. As such, no further action on this project is warranted.”

MPFS 2020

“Global Surgical Codes

The AANS and the CNS strongly object to the failure of CMS to incorporate the adjusted values for the revised office/outpatient E/M codes into the global surgical codes. By setting aside the explicit recommendations from the RUC, and failing to incorporate the recommended work and time values for the revised office visit E/M codes for CY 2021 into adjustments to the 10- and 90-day global codes, CMS improperly proposes to implement these new E/M values in an arbitrary fashion that specifically undervalues the work of providers performing 10- and 90-day global procedures. **If CMS adopts the RUC approved office/outpatient E/M code values, the agency must also apply these updated values to the global codes.** Doing otherwise will:

- **Disrupt resource-based relativity in the fee schedule.** When the Resource-Based Relative Value Scale (RBRVS) was first implemented, global periods were developed for surgical procedures. Global periods include E/M post-operative visits, so the procedure values are resource-based and

relative to non-procedural parts of the PFS. Applying the RUC-recommended E/M values to stand-alone E/M codes, but not to the E/M work included in the global surgical package, would disrupt the relativity between procedural and non-procedural codes that forms the bedrock of RBRVS, which has been refined by CMS and the RUC over the past 27 years.

Since the inception of the fee schedule, E/M codes have been revalued four times:

- In 1993, through refinement after implementation of extensive E/M coding changes;
- In 1997, after the first five-year review;
- In 2007, after the third five-year review; and
- In 2011, after CMS eliminated consult codes and moved work RVUs into the office visit codes.

Each time, when payments for new and established office visits were changed, CMS incorporated these changes into the post-operative visits within the global period. CMS has provided an unsatisfactory rationale for failing to incorporate the proposed E/M code increases in the CY 2020 Medicare PFS, and in the absence of a compelling rationale, CMS should maintain precedent and preserve relativity across the PFS.

- **Create specialty differentials.** Per the Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the “Secretary may not vary the...number of relative value units for a physicians’ service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.” Failing to adjust the global codes will invariably pay some physicians less for providing the same E/M services, in violation of the law. As discussed below, the AANS and the CNS strongly dispute the suggestion from the RAND reports that care provided by surgeons in the global period is different, and cognitively less difficult, than that provided by cognitive specialists. RAND states, “For example, a practitioner may only need to examine the wound site when addressing a potential post-operative infection.” To suggest that surgeons merely assess surgical wounds and are not engaging in a holistic view of their surgical patients with coordination of care in a multi-disciplinary fashion is not only insulting, it is refuted by Medicare data showing that transitional care management codes (CPT 99495 & 99496) were only billed approximately 1.2 million times in 2018. Most of these instances related to non-procedure-related hospitalizations, which further supports the fact that surgeons are providing the primary care of their patients during the global period.
- **Violate section 523(a) of MACRA.** CMS points to the ongoing global code data collection effort as a reason for not applying the RUC-recommended changes to office visit E/M codes to global codes. In addition, the agency states that it is required to update global code values based on objective data on all of the resources used to furnish the services included in the global package. These arguments conflate two separate issues. The issue that CMS raises regarding MACRA legislation is not related to maintaining relativity across the fee schedule based on current data in the CMS work/time file. In fact, section 523(a) specifically authorizes CMS to make adjustments to surgical services, notwithstanding the mandate concomitantly to undertake the MACRA-mandated global code data collection project.
- **Ignore recommendations endorsed by nearly all medical specialties.** As mentioned above, the RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full increase of work and physician time for office visits be incorporated into the global periods for all 10- and 90-day CPT codes. The RUC also recommends that the practice expense inputs should be modified for the office visits within the global periods.

RAND Reports on Global Surgical Codes

As part of MACRA, Congress mandated that CMS collect data on the number and level of post-operative visits for global surgical services provided to Medicare beneficiaries. The law stipulated for CMS to use these and other available data, as appropriate, to improve the valuation of global surgical services. The AANS and the CNS have long believed that the MACRA requirement was inadvisable and unnecessary, as CMS already has in place a process for reviewing and adjusting the value of surgical services with input from the RUC. CMS has collected data, and we believe that the agency's data collection project has met the requirements of the statute, and the agency should abandon any intention of eliminating the global surgical periods. CMS expresses in the proposed rule its interest in increasing bundled payments under the Medicare PFS. If this is the goal of the agency, it is counter-intuitive to attempt to deconstruct bundled payment for surgical procedures. These bundled procedures include all pre-operative work in the 24 hours before surgery, the surgery itself, and then post-operative work on the date of the surgery and in the 10 or 90 days following. These services include not only direct face-to-face interactions with the patient and family, but also care management services.

We have reviewed the three RAND reports, and they only serve to reinforce our position that the MACRA requirement to review global surgical services was a waste of time and resources. We support the RUC comments regarding the flaws in the three RAND reports. To the extent there may be specific outlier global surgical procedures that have not recently been reviewed by the RUC, CMS can follow well-established precedent by identifying those codes as potentially misvalued and allow the RUC to conduct a thorough review without a sweeping, useless and burdensome disruption to surgeons and their patients. Otherwise, no further action on this project is warranted. Below are some additional comments on each of the RAND Reports.

- **RAND Report 1, Claims-Based Reporting of Post-Operative Visits for Procedures with 10- or 90-Day Global Periods.** Since July 1, 2017, Medicare practitioners in nine states have been required to report on the postoperative visits they furnish during the global period of specified procedures using CPT code 99024, *Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure.* The 299 10-day or 90-day global surgical procedures included in this initiative are those that are furnished by more than 100 practitioners, and either are nationally furnished more than 10,000 times annually or have more than \$10 million in annual allowed charges.

The AANS and the CNS agree with the RUC that this dataset cannot reasonably be used to forecast any overall trends, given the limited and likely intermittent participation of eligible physicians as well as the current difficulty the agency and RAND researchers have implied in matching up procedures to CPT code 99024. Only 46 percent of practitioners that were expected to participate submitted tracking code 99024 through June 2018. Fifty-four percent of physicians eligible for this data collection project were either not aware of the requirement to participate or were unable to participate for another reason. Also, only 17 percent of eligible physicians were classified as "robust reporters," indicating that a majority of those that did participate did so intermittently or did not begin until partway through the reporting period. If most of the eligible providers did not participate for a CPT code, which was the case for many codes, the median count of post-op visits would be zero irrespective of what study participants reported, and the mean number of visits would be greatly understated.

Furthermore, the dataset that includes only practices with 10 or more practitioners is potentially not representative as most physicians are in practices that have fewer than 10 providers. The AMA 2018 Physician Practice Benchmark Survey indicated that 54 percent of physicians are in practices with fewer than 10 physicians. Also, for surgical specialties, 64 percent of physicians are in practices with fewer than 10 physicians. We are especially concerned about this issue with practicing neurosurgeons, who often practice in groups smaller than 10.

The AANS and the CNS strongly disagree with the RAND conclusion that only 39 percent of 90-day global visits and 4 percent of 10-day global visits were performed. There are many flaws in the computation to arrive at these figures. First, 54 percent of physicians in the nine states who were eligible to participate did not do so. RAND inappropriately assumes that each of these physicians did not provide any office visits in any surgery's global period. RAND also did not make any distinction between post-operative visits performed in the hospital setting versus those in office. For many neurosurgeons, whose patients can spend several days in the hospital, this is problematic. For physicians who use a separate electronic health record system in the office than the hospital where they perform surgery, there may be challenges in capturing and submitting claims for post-operative in-hospital visits. RAND also acknowledged the difficulty in matching 99024 visits to their associated procedures. The researchers chose to limit the potential confounder of multiple procedures performed during the same global period by focusing their analysis on so-called "clean" procedures — that is, procedures with no overlap with any other procedures during the ensuring global period. This, however, led to a significant reduction of available so-called "clean" procedures, which represented only about 60 percent of the available 90-day global procedures. However, for procedures in the category of "Nervous System: Spine and Spinal Cord," this represented less than 40 percent of the available procedures. The information gathered cannot be extrapolated to all 10- and 90-day surgical global services, and **the AANS and the CNS recommend that CMS not implement any changes in the global surgical services based on the RAND sample of physicians reporting CPT code 99024 and abandon further data collection altogether.**

- **RAND Report 2: Survey-Based Reporting of Post-Operative Visits for Select Procedures with 10- or 90-Day Global Periods.** To comply with MACRA's requirement for CMS to collect data on the level of post-operative visits for global services, CMS contracted with RAND to conduct a survey to collect additional data on post-operative services, including the level of post-operative services. RAND launched a pilot of the survey in the fall of 2017 with a sample size of 557 practitioners and received only a single complete response. Following this setback, CMS and RAND decided to greatly narrow the scope of their survey initiative to only three high-volume services: cataract surgery (only CPT code 66984), hip arthroplasty (only CPT code 27130) and complex wound repair (CPT codes 13100, 13101, 13120, 13121, 13131, 13132, 13151, and 13152).

Beyond the obvious limitations of the survey instrument examining less than one thousand physicians who perform three procedures, RAND's main conclusion in the second report is flawed. They assert that the average visits were somewhat shorter than anticipated for cataract surgery (16.4 minutes vs. 19.4 minutes) and hip arthroplasty (22.9 minutes vs. 29.6 minutes) and longer for complex wound repair (21.8 minutes vs 16 minutes). However, RAND misinterpreted the findings of their survey data as they compared only the survey physician time "on the day of the visit" to the CMS physician time file, where the pre-service and post-service time of E/M services are not specific to the date of the encounter. The researchers also inappropriately excluded nurse practitioner (NP) and physician assistant (PA) time from their visit time comparison analysis. Additionally, in 2019, time is not the only factor relevant in selecting a code level.

RAND categorized NP/PA survey data as “staff time” and incorrectly observed that “...such staff time would be considered as part of PE in the RUC process and not contribute to the physician time component nor to the level of the visit.” While this is the case for work performed by clinical staff, this is never the case for qualified health care professionals who can separately report Medicare services. The researchers did not account for Medicare rules on “incident to” and split/shared E/M services. When an NP or PA assists with an office visit, both the work of the physician and the work of the NP/PA is used to select the level of the visit if the requirements for “incident to” are met and the patient is an established patient.

Most importantly, the new E/M office visit framework allows for a physician to report a 99212 if 10 minutes is spent on the date of the encounter. Most surgical post-operative office visits are attributed as 99212 in the global surgical period in determining physician work, physician time and practice expense. The RAND survey instrument had significant methodological flaws, but the new coding structure developed by the RUC renders this RAND report moot.

- **Rand Report 3: Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- and 90-Day Global Periods.** This third study used the reverse building block methodology to estimate the change in Medicare payment based on RAND’s summary data from the first study. The analysis included in this study is extremely flawed and disingenuous, as the researchers completely disregarded the “robust reporters” concept highlighted in the first study and made no attempt to filter out the 54 percent of eligible providers that did not participate in the data collection initiative. When 54 percent of eligible providers were assumed never to perform post-operative visits simply because they were not aware or were unable to participate in the data collection project, the median number of visits for many surgical global codes would be zero irrespective of what participating physicians reported. Also, as no specialty achieved a 100 percent participation rate, all codes included in the study would have been undercounted in the study to some extent.

For neurosurgery, specifically, the numbers extrapolated by RAND based on their claims data bear no resemblance to actual clinical practice. For example, two of the 15 neurosurgical codes captured by the RAND analysis, CPT codes 61312 and 61510, represent craniotomy codes, one for the evacuation of a hemorrhage and the other for the resection of intracranial tumor. Both of the patient populations represented by these procedures are medically complex and typically are seen multiple times — both in the hospital (often in intensive care unit setting) as well as in the clinic in the global period. However, according to the RAND analysis, the most common (mode) number of post-operative visits for these two procedures was zero, meaning that RAND concluded that neurosurgeons *never* see patients who have undergone these procedures in the post-operative period. Obviously, this is grossly inaccurate and highlights the lack of utility in the RAND data. It is not reasonable to draw any conclusions from this flawed data or to make any significant changes in the payment of the global codes based on these findings.

The AANS and the CNS concur with the AMA and RUC, which object to the “reverse building block methodology” to systematically reduce work RVUs for services. We contend that the reverse building block methodology, or any other purely formulaic approach, should never be used as the primary methodology to value services. It is inappropriate as magnitude estimation has been used to establish work RVUs for services since the publication of the first Medicare physician payment schedule in 1992. This methodology, for example, ignores the care coordination work that is performed during the global surgical period, as evidenced by the flawed analysis in the RAND survey of hip arthroplasty.

Implementation of the methodology outlined in this RAND report would result in unreasonable reductions in total Medicare payment for many surgical specialties, putting at risk access to care for Medicare beneficiaries (e.g., payment reductions of 18.4% for cardiac surgery, 18.1% for surgical oncology, and 13.5% for neurosurgery). If CMS moves forward with the RAND recommendations, we anticipate dire unintended consequences for access to care for Medicare beneficiaries as some practitioners in these specialties may be forced to abandon Medicare altogether.

In summary, the results from the RAND studies should not be used to justify distorting the relativity of office visits within the RBRVS. Again, we point out the RUC voted 27-1 for CMS to apply the RUC office visit recommendations to both the stand-alone E/M office visit codes and the E/M office visit component of the codes with global periods. **We urge CMS to finalize a policy that adopts this recommendation for 2021. Furthermore, we believe the agency has fulfilled its requirement to collect data on global surgery services and should, therefore, drop further efforts to systematically eliminate the global periods.”**

MPFS 2021

“Include the E/M Increases in the Global Surgery Codes

Once again, CMS has stated that it will not adjust the E/M portion of the global surgery codes to reflect the changes in values of the revised stand-alone office and outpatient E/M codes. The refusal to incorporate the work and time incremental increases for the revised office/outpatient visit codes in the E/M portion of the global surgery codes is entirely unacceptable and in contravention of the Medicare statute. This policy, coupled with other ill-conceived changes in the proposed PFS, will result in drastic cuts to neurosurgeons.

As the agency proceeds to implement the changes to the office and outpatient visit codes — which are based on the AMA CPT/RUC E/M Workgroup recommendations — **we strongly request that CMS apply the RUC-recommended adjustments to the global surgery codes starting in Calendar Year (CY) 2021.** To do otherwise will:

- **Disrupt the relativity in the fee schedule.** Applying the RUC-recommended E/M value increases to the stand-alone office and outpatient visits and select bundled codes that include E/M services (e.g., monthly end-stage renal disease, maternity care and monthly psychiatric management), but *not* also to the E/M portion of the global surgical codes, will disrupt the relativity between codes across the Medicare PFS. Congress mandated this relativity in the Omnibus Budget Reconciliation Act of 1989, which is the cornerstone of the Medicare PFS as established in 1992 and refined over the past 27 years.
- **Disregard previous precedent.** Since the inception of the fee schedule, the E/M codes have been revalued four times:
 - + In 1993, through refinement after implementation of extensive E/M coding changes;
 - + In 1997, after the first five-year review;
 - + In 2007, after the third five-year review; and
 - + In 2011, after CMS eliminated consult codes and moved work RVUs into the office visit codes.

Each time payments for new and established office visits were changed, CMS appropriately incorporated these changes into the post-operative visits within the global period. There is simply no

valid reason for the agency not to make these same adjustments now, and CMS should follow its own precedent by adjusting the E/M portion of the global codes accordingly.

- **Create specialty differentials.** The Medicare statute prohibits CMS from paying physicians differently for the same work. According to the law, the “Secretary may not vary the . . . number of relative value units for a physicians’ service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.” Failing to adjust the global codes is tantamount to paying some physicians less for providing the same E/M services, in violation of the law.

In the CY 2021 PFS proposed rule, CMS asserts that the valuation methodology (i.e., building block vs. magnitude estimation) provides a rationale for why some bundled services should be increased, while the global surgery codes should not. These distinctions are flawed and fail to adhere to the statutory prohibition on paying physicians differently for the same work — which applies irrespective of the valuation methodology — and the incremental E/M-related increases should apply to all services, including the global surgery codes.

- **Inappropriately rely on section 523(a) of MACRA.** In the CY 2021 PFS proposed rule, CMS states it will not adjust the 10- and 90-day global surgical codes to reflect the increased values of the office and outpatient E/M visit codes because the agency continues to collect data on the number and level of post-operative visits included in global codes as required by the Medicare Access and CHIP Reauthorization Act (MACRA).

The MACRA data collection requirement, set forth in section 523(a), does not prohibit CMS from adjusting the global codes to reflect the new office/outpatient E/Ms code values. In fact, section 523(a) explicitly authorizes CMS to adjust global surgical code values, notwithstanding the mandate to concomitantly undertake the MACRA-mandated global code data collection project. Therefore, it is inappropriate for CMS to rely on MACRA as a reason to refrain from making necessary updates in 2021.

Furthermore, the AANS and the CNS believe that the agency has fulfilled its MACRA requirement to collect data on the global surgical codes. As we, the RUC, the ACS and other stakeholders have pointed out, the RAND studies of the global surgical codes are highly flawed. Rather than relying on this flawed and incomplete work to propose any future changes to the global surgery codes, CMS should instead utilize the RUC process to review code values periodically. This process was recently used, for example, to revalue the cataract code and can be effectively employed on a code-by-code basis, as contemplated by section 523(a).

- **Ignore recommendations endorsed by nearly all medical specialties.** In 2019, the RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full, incremental increase of work and physician time for office visits be incorporated into the global codes for each CPT code with a global period of 10-day, 90-day and MMM (maternity). The RUC also recommended modifying the practice expense inputs for the office visits within the global periods. In the CY 2021 PFS proposed rule, CMS uses the RUC recommendations as a rationale for increasing the values of the maternity services codes and other select bundled services. However, at the same time, the agency rejects the RUC recommendations related to the global surgery codes. Cherry-picking the RUC recommendations is arbitrary and capricious in violation of the Administrative Procedures Act.

Again, we strongly urge CMS to apply the RUC-recommended changes to the E/M component of the global surgery codes to maintain the fee schedule’s relativity and comply with the Medicare

law’s prohibition on specialty payment differentials. Furthermore, we believe the agency has fulfilled its requirement to collect data on global surgery services and, therefore, should drop further efforts to systematically devalue or eliminate the global surgical codes.”

MPFS 2022

“Failure to Include the E/M Increases in the Global Surgery Codes. Once again, CMS has inappropriately failed to incorporate the increases in office/outpatient E/M values into the 10- and 90-day global surgery codes — even though the agency did make these adjustments to other bundled services, such as maternity codes, in the CY 2021 Medicare PFS rule. Organized medicine has been united in its recommendations that CMS incorporate the incremental revised office/outpatient E/M values into all 10- and 90-day global surgical codes, as evidenced by the many comment letters and meetings over the past several years. The failure to incorporate proportionate increases in the global codes results in an unfair, across-the-board, systematic devaluation of surgical services.

We reiterate that it is inappropriate that CMS has not applied the RUC-recommended changes to the global codes. The refusal to incorporate the work and time incremental increases for the revised office/outpatient visit codes in the E/M portion of the global surgery codes is entirely unacceptable. Failure to incorporate the increased E/M work in the global codes will:

- + Disrupt the relativity in the fee schedule. Applying the RUC-recommended E/M value increases to the stand-alone office and outpatient visits and select bundled codes that include E/M services (e.g., monthly end-stage renal disease, maternity care and monthly psychiatric management), but *not* also to the E/M portion of the global surgical codes, will disrupt the relativity between codes across the Medicare PFS. Congress mandated this relativity in the Omnibus Budget Reconciliation Act of 1989, which is the cornerstone of the Medicare PFS as established in 1992 and refined over the past 27 years.
- + Disregard previous precedent. Since the inception of the fee schedule, the E/M codes have been revalued four times:
 - In 1993, through refinement after implementation of extensive E/M coding changes;
 - In 1997, after the first five-year review;
 - In 2007, after the third five-year review; and
- + In 2011, after CMS eliminated consult codes and moved work RVUs into the office visit codes.

Each time payments for new and established office visits were changed, CMS appropriately incorporated these changes into the post-operative visits within the global period. There is simply no valid reason for the agency not to make these same adjustments now, and CMS should follow its own precedent by adjusting the E/M portion of the global codes accordingly.

- + Create specialty differentials. The Medicare statute prohibits CMS from paying physicians differently for the same work. According to the law, the “Secretary may not vary the . . . number of relative value units for a physicians’ service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.” Failing to adjust the global codes is tantamount to paying some physicians less for providing the same E/M services, violating the law.
- + Ignore recommendations endorsed by nearly all medical specialties. In 2019, the RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full, incremental increase of work and physician time for office visits be incorporated into the

global codes for each CPT code with a global period of 10-day, 90-day and MMM (maternity). The RUC also recommended modifying the practice expense inputs for the office visits within the global periods. In the CY 2021 PFS proposed rule, CMS used the RUC recommendations as a rationale for increasing the values of the maternity services codes and other select bundled services. However, at the same time, the agency rejected the RUC recommendations related to the global surgery codes. Cherry-picking the RUC recommendations is arbitrary and capricious in violation of the Administrative Procedures Act.

Again, the AANS and the CNS urge CMS to apply the RUC-recommended changes to the E/M component of the global surgery codes to maintain the fee schedule's relativity and comply with the Medicare law's prohibition on specialty payment differentials. Furthermore, we believe CMS has fulfilled its requirement to collect data on global surgery services and, therefore, should cease ongoing efforts to systematically devalue or eliminate the global surgical codes.

American Association of Orthopaedic Surgeons

Medicare Physician Fee Schedule (MPFS) 2017

“Collection of Data Related to the Resources Used in Furnishing of Global Services: The AAOS is very concerned with the methodology proposed by CMS to review and measure resources used in the provision of global services under the MPFS. In particular, the AAOS is concerned that the steps proposed by CMS, particularly the requirement that all providers use G-codes for all post-operative patient encounters are unnecessarily burdensome for physician and physician practices, will result in inaccurate data, and represent an overreach by the agency according to the language in the Medicare and CHIP Reauthorization Act (MACRA) of 2015 calling for CMS to collect data on resources used in the post-operative global period. AAOS strongly urges CMS to significantly revise their proposed methodology to not use the G-codes as proposed, to not make the claims reporting universal to all Medicare providers using global period codes, and to utilize representative samples of services and other approaches that are likely to yield more reliable and accurate data without imposing major burdens on hundreds of thousands of providers.”

MPFS 2018

“Preservice Clinical Labor for 0-Day and 10-Day Global Services CMS indicates that for the 1142 0-day global codes, 741 of the codes had preservice clinical labor of some kind (65 percent). CMS also noticed a general correlation between preservice clinical labor time and when the code was reviewed. CMS is seeking comment specifically on whether the standard preservice clinical labor time of zero minutes should be consistently applied for all 0-day and 10-day global codes in future rulemaking.

The RUC Practice Expense (PE) Subcommittee assumes that 0- and 10-day global codes have no preservice clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any preservice time is appropriate. The RUC agreed that - with evidence - some subset of codes in the facility setting may require minimal use of clinical staff and the RUC has allocated 15 minutes when appropriate. The RUC also agreed that with evidence some subset of codes may require extensive use of clinical staff and has allocated 18 minutes for the non-facility and 30 minutes for the facility when appropriate. On a case-by-case basis, the RUC PE Subcommittee reviews the evidence that is submitted to determine if the evidence justifies preservice time. For example, many recently reviewed interventional codes are actually major procedures, but have been assigned a 0-day global status. Clinical staff pre-service work is consistent with 90-day global codes. However, because these codes are 0-day, the preservice clinical staff work has been discounted. Another example is with the endoscopy services, where clinical staff will, among other activities, coordinate clearance for anesthesia and confirm diet and bowel prep. This necessary preservice clinical staff work cannot be performed on the day of the procedure after the patient has arrived. This is different from "minor" procedures (for example, laceration repair) where minimal or no preservice clinical staff work is required.

We believe that CMS is only seeing a "trend" because of the significant number of 0-day endoscopy and interventional codes that have recently been reviewed. If CMS considers "minor" procedures in the mix (for example, lesion excision), they will see that the RUC PE Subcommittee assigns zero minutes appropriately.

The AAOS respectfully disagrees with the proposal that all 0-day and 10-day global codes should have zero preservice clinical staff time and urges CMS to allow the RUC PE Subcommittee to continue to review compelling evidence on a code-by-code basis to determine the need for preservice clinical staff time.”

MPFS 2019

"Update on the Global Surgery Data Collection

CMS believes the minimal 99024 reporting during 10-day global periods suggests that post-operative visits are not typically being furnished. CMS requested feedback on alternative explanations for the low percentage of reporting of this code.

The AAOS appreciates the intention to use the data already gathered to further evaluate an explanation for low reporting, but we do not have the raw data for the procedures, beneficiaries, and specialties that CMS used for analysis. In the presentation of statistics, CMS notes that "multiple procedures performed on a single day and procedures with overlapping global periods were excluded because matching may be unclear in these circumstances." Although CMS indicates it excluded records where more than one code was reported on the same date, we wonder if codes reported with modifiers were considered. For example, a 10-day global code, reported almost exclusively by orthopaedic surgeons, was also reported with modifier 58 (Unplanned Return to the Operating/Procedure Room by the Same Physician or Other QHP Following Initial Procedure for a Related Procedure During the Postoperative Period) 50 percent of the time. Modifier 58 does not reset the global period of the primary procedure and is paid at a reduced rate. This is also true for several other 10-day global codes reported by orthopaedic surgeons. It is possible that a post-op visit was performed, but not reported in conjunction with procedures reported with modifier 58. Instead, the visit would have been related to another 90-day global primary procedure that may or may not have been on the list of codes under review by CMS.

Alternatively, the measured low frequency of post-operative visits in the 10-day global period could be explained by system and process errors. CMS conducted research and collected data to assess whether global codes are correctly valued. If there were accurate and valid data to indicate that a visit is "not typical", the code should be revalued using a standard RUC process. However, the data did not show that global codes are misvalued and we believe CMS has met its statutory requirements.

Regarding "transfer of care" modifiers (-54, -55), it is our opinion that the formal transfer of care policy is clear and should be used when postoperative office visits are transferred to another provider. For orthopaedic surgeons, this might occur if a patient is treated for a fracture, while on vacation or in an emergency department, but follow-up is assumed by another provider. We believe orthopaedic surgeons understand how to report the correct modifiers and that a change in policy is unnecessary."

MPFS 2020

"Global Surgical Packages

If CMS decides to finalize the office/outpatient E/M visit revaluation, **we urge you to extend the updates to the global surgical codes.** Procedures with a 10- and 90-day global period have postoperative visits included in their valuation. CMS mistakenly states that the visits in the global package codes are not directly included in the valuation. Rather, the work RVUs for procedures with a global period are generally valued using magnitude estimation. We believe that CMS has conflated the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation requirement to review the number and level of visits in global codes with maintaining relativity across the fee schedule based on current data in the CMS work/time file. These two issues are not related.

Earlier in August 2019, we joined several surgical specialties in writing to you stating that not extending the E/M will disrupt the relativity in the physician fee schedule, create specialty differences and may even violate MACRA section 523(a) statutory requirements."

Opportunities for Bundled Payments under the PFS

In this proposed rule, CMS has requested information on opportunities to use bundled payment models to improve payments for services that are provided together. CMS notes that the statute requires the Agency to pay for physicians' services based on the relative resources involved in furnishing the service but otherwise allows considerable flexibility for developing payment structure under the RBRVS. As you are aware, codes with assigned global periods of 10 or 90 days have multiple distinct services bundled into one payment amount. The AMA/RUC and CPT Editorial Panel have considerable experience developing episodes of care for various medical specialties and diseases. Hence, we urge CMS to work with the RUC, CPT and medical specialties to develop such bundled payments.

Earlier this summer, we participated in listening sessions with the CMS Innovation Center and staff from your office at CMS to discuss longitudinal models for specialty care. **As the leaders in musculoskeletal care, we urge CMS to include orthopaedic surgeons and other specialists in designing bundled chronic care models."**

MPFS 2021

"Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/ Outpatient Evaluation and Management Visits (E/M)

In the Medicare Physician Fee Schedule (MPFS) Proposed Rule, CMS states that they recognize that there are services other than the global surgical codes for which the values are closely tied to the values of the office/outpatient E/M visit codes. CMS identified specific codes, adjusting the relative value units (RVUs) for these services.

AAOS strongly opposes CMS' failure to incorporate the RUC-recommended work and time incremental increases for the revised office/outpatient visit E/M codes in all the global codes. We find this unacceptable given that adjustments proposed for other bundled services, such as the maternity services, have this update applied to their global codes. Organized medicine has been united in its recommendations that CMS incorporate the incremental revised office/outpatient E/M values in the global codes, as evidenced by the many comment letters and meetings over the past year. We are, therefore, extremely disappointed that CMS continues to ignore these recommendations, from nearly all medical specialties, in the CY 2021 MPFS proposed rule.

AAOS would like to reiterate that it is inappropriate for CMS not to apply the RUC-recommended changes to global codes starting in CY 2021. Applying the RUC-recommended E/M value increases to stand-alone E/Ms, select global codes (e.g., monthly end-stage renal disease and bundled maternity care), and select bundled services (e.g., monthly psychiatric management), but not to the E/Ms that are included in the global surgical package will result in disrupted relativity between codes across the MPFS. Changing the values for some bundled services that include E/M services, but not for others, disrupts this relativity, which was mandated by Congress in 1992, and refined over the past 27 years.

Per the Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the "Secretary may not vary the . . . number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician."¹ Failing to adjust the global codes is tantamount to paying some doctors less for providing the same E/M services, in violation of the law. In the CY 2021 MPFS proposed rule, CMS points to the method of valuation (i.e. building block vs. magnitude estimation) for a rationale as to why some

bundled services should be increased in value to reflect the revised office/outpatient E/M values, while global codes should not. However, this statutory prohibition on paying physicians differently for the same work applies regardless of code valuation method and the incremental increases should apply to all physicians.

In addition, CMS’ proposal to reduce the conversion factor by 10.6% paired with the failure to incorporate the revised office/outpatient E/M values in the global codes will result in drastic cuts to many physician specialties. These cuts come at a time when specialists are struggling with the financial impact of the COVID-19 pandemic such as, suspension of elective surgery, salary reductions, furloughs, and layoffs.

Again, AAOS strongly urges CMS to apply the RUC-recommended changes to the E/M component of the global codes to maintain the relativity of the Fee Schedule.

At the October 2019 RUC meeting, AAOS and AAHKS recommended that the RUC maintain the current work RVUs of 20.72 for codes 27130 and 27447, which is below the 25th percentile of survey work RVUs of 22.50 and 22.14, respectively. These recommendations were based on the results from the survey indicating a median intra-service time of 100 minutes for 27130 (equal to the intra-service time from the 2013 RUC survey) and of 97 minutes for 27447 (three minutes less than then 100 minutes from the 2013 RUC survey) and the pre-service and post-service times from the survey which included two hospital visits, a hospital discharge visit, and three post-discharge office visits in the 90-day global period, with an additional 30 minutes of pre-service time for the time surgeons and/or QHPs spend in pre-operative optimization activities. The total time for 27130, with these recommended times, are equal to the 2013 CMS accepted times of 407 minutes for 27130 and a reduction of three minutes to 404 minutes for 27447. A copy of this presentation is attached below as Appendix A.

| Table 1. Comparison of wRVU Survey Results and Recommendations for CPT Codes 27130 & 27447 Current wRVU | Median wRVU RUC Survey Results | 25th Percentile of wRVU RUC Survey Results | AAOS & AAHKS Recommended wRVU | RUC-recommended wRVU |
|--|---------------------------------------|---|--|-----------------------------|
| 20.72 | 24.00 | 22.50 (THA) 22.14 (TKA) | 20.72 | 19.60 |

The RUC did not accept the initial recommendations and instead recommended a work RVU of 19.60 for both codes. AAOS strongly disagrees with these recommendations and urges CMS to accept the AAOS and AAHKS recommended times and work RVUs for codes 27130 and 27447. We believe the 2019 survey supports the 2013 survey data for the intra-time and post-operative office time. Along with the additional data presented on 30 minutes of additional pre-service physician and/or QHP time spent on pre-optimization activities, we believe the 2019 survey supports the 2013 survey data for the intra-time and post-operative office time. Along with the additional data presented on 30 minutes of additional pre-service physician and/or QHP time spent on pre-optimization activities, we believe that the correct total times for 27130 and 27447 are 407 minutes and 404 minutes, respectively.”

MPFS 2022

"Global Codes Update

AAOS would also like to remind CMS that it is inappropriate for CMS not to apply the RUC-

recommended changes to the global codes. **AAOS strongly urges CMS to reconsider this policy and apply the E/M value increases from CY 2021 to the global codes.** AAOS continues to find CMS' failure to incorporate the incremental increase for work and time for the revised office/outpatient visit E/M codes in all global codes unacceptable. Including the value increases to all global codes is essential to maintain fee schedule relativity.”

Critical Care Visits and Global Surgery

CMS proposes to bundle critical care visits with procedure codes that have a global surgical period. CMS should not finalize this policy as proposed. The AAOS strongly opposes a proposal that would prevent surgeons from being able to appropriately use modifier -24 (*Unrelated E/M Service During Post-Operative Period*) or modifier -25 (*Significant Separately Identifiable E/M Service on the Same Day of a Procedure or Other Service*). Not only do CMS' rationales not support this policy, but this policy will prevent surgeons who provide both operative and critical care services from being fairly reimbursed for their time spent legitimately caring for some of their sickest patients in and out of the operating room.

Specifically, this policy undervalues the ICU care required for some post-surgical patients and undervalues the expertise of those intensivist surgeons caring for the most complex patients. Most surgical patients do not require ICU care, and ICU care is not included in the value of most 10- and 90- day global codes. But some patients are either already critically ill when requiring surgery or become critically ill unpredictably after surgery. In these cases, surgeons and surgical intensivists are best equipped to manage the critical care services for these patients postoperatively. The surgeons are most familiar with their patient's case and their postoperative course. They are also most familiar with complex operations and the impact of comorbidities. And surgeons have the best skillset to identify and manage postoperative issues as well as recognize the expectations/pitfalls of surgery. The critical care that surgeons provide accounts for the constant attention, availability, interaction, and coordination with multiple other specialties that may be required for these patients.

CMS should instead maintain the current provision in the Medicare Claims Processing Manual that specifically allows modifiers -24 and -25 to be used to indicate that the critical care service can be billed when unrelated to the procedure. This section states:

Critical care services provided during a global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances.

Preoperative and postoperative critical care may be paid in addition to a global fee if:

- The patient is critically ill and requires the constant attendance of the physician; and
- The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed.

Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

Modifier -24 (post-operative) or -25 (same day pre-operative) is used to indicate that the critical care service is unrelated to the procedure.”

American College of Surgeons

Medicare Physician Fee Schedule (MPFS) 2013

“Improving the Valuation of the Global Surgical Package

CMS seeks comments on methods for obtaining accurate and current data on evaluation and management (E/M) services furnished as part of the global surgical package. In the proposed rule, CMS reviews the results of several studies by the Office of Inspector General (OIG) that have called into question whether E/M services in various global surgical packages are actually furnished to Medicare beneficiaries. Specifically, the studies indicated that in the limited number of records reviewed, the E/M services do not match the current CMS time and visit database.

Global surgical payments are based on typical work, but allow for variations in the actual post-operative services that may result in more or less work than the typical. According to the surgical package definition in the surgery guidelines of Current Procedural Terminology (CPT®), “the services provided by the physician, as part of the global surgical package, to any patient by their very nature are variable.”² We have serious concerns that the OIG review lacks credibility due to the fact that it is based on limited data. The OIG report is based on a review of 300 claims for almost 300 procedure codes, which results in a small subset of claims reviewed per procedure. Furthermore, many of the codes identified by the OIG have since been reviewed by the AMA RUC as potentially misvalued services with reductions in relative value work units and reductions in visits. Therefore, it is not surprising that the OIG’s random selection of a few patient files per code from 2007 shows variation from what has been determined to be typical.

We also acknowledge that documentation problems could make it difficult to determine which services were actually furnished, since these services are not typically billed separately under a global surgical policy. It is important to note that documentation guidelines have never been designed nor proposed for application in global period. In other words, failure to find documentation of each and every E/M service furnished during the global surgical period is not definitive evidence that the services were not furnished. The proposed rule acknowledges as much.

The AMA RUC collects data on the level of E/M visit, while the OIG report did not. The OIG review should not be considered to be more reliable than the information obtained from the national medical specialty societies and peer reviewed by the AMA RUC. The ACS continues to support the AMA RUC’s thoughtful and deliberative process for evaluating codes, which utilizes standard physician work estimation surveys to set the global surgical payment. As a peer review group, all specialties participate and judge the data as presented. Isolated cases and anecdotal information are not accepted as typical. If further study of this issue is to be done, we urge CMS to continue to work with the AMA RUC and specialty societies to complete a rigorous and thorough review of a large representative sample of AMA RUC-reviewed procedure codes.”

MPFS 2015

“Improving the Valuation and Coding of the 10- and 90-Day Global Surgical Package

The Centers for Medicare & Medicaid Services (CMS) finalized the proposal to transition all 10- and 90-day global surgical codes to 0-day global surgical codes by 2017 and 2018, respectively. **We continue to urge CMS not to move forward with this policy without first developing a sound methodology that takes into account stakeholder input and has been tested to ensure there is no**

negative impact on patient care and access. Many of our concerns described in our comment letter to the CY 2015 Medicare Physician Fee Schedule proposed rule remain, including the time frame and scope of the policy, implementation considerations, and unintended and unknown consequences. We are analyzing this policy change and will follow up with CMS in the coming months. We look forward to continuing dialogue with CMS on this important issue.”

MPFS 2016

“Improving the Valuation and Coding of the Global Package

Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to use rulemaking to obtain information needed to value surgical services from a representative sample of physicians, and requires that the data collection begin no later than January 1, 2017. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery, as appropriate. This information must be reported on claims or in another manner specified by the Secretary. The Secretary is also authorized through rulemaking, to delay up to 5 percent of the PFS payment for services, for which a physician is required to report information, until the required information is reported. Beginning in 2019, the information collected, along with any other available data, must be used to improve the accuracy of the valuation of surgical services.

CMS seeks feedback on a number of issues related to the data collection and valuation of global services. We provide high-level comments on each issue below, and we plan to communicate further with CMS in the coming months to discuss in more detail CMS’ plan for data collection and valuation of surgical services. We very much appreciate that CMS plans to seek comments, in addition to the rulemaking process, for developing a proposal for CY 2017 to collect data needed to value surgical services. We urge CMS to utilize any available means to obtain comments including open door forums and town hall meetings with the public, amongst other avenues. We also urge CMS to allow stakeholders to provide additional written comments on policies that CMS is developing for collecting these data, either in the form of a response to a request for information (RFI), written comments following a town hall, or by some other mechanism.

Types of data and how to acquire the data

CMS is soliciting comments from the public regarding the kinds of auditable, objective data (including the number and type of visits and other services furnished by the practitioner reporting the procedure code during the current post-operative periods) needed to increase the accuracy of the values for surgical services. CMS is also seeking comment on the most efficient means of acquiring these data as accurately and efficiently as possible. For example, CMS seeks information on the extent to which individual practitioners or practices may currently maintain their own data on services, including those furnished during the post-operative period, and how the agency might collect and objectively evaluate those data for use in increasing the accuracy of the values beginning in CY 2019.

We urge CMS to utilize a number of different data sources to collect data for increasing the accuracy of the values for surgical services. Different data sources will be needed to capture information on the procedure itself, the postoperative visits, preoperative services, and other services provided. **We also stress that the data must be truly representative and must include information from geographically diverse large and small practices.** It will not be possible to obtain all the needed information that is representative of services delivered to patients across our country from a single data source or even two or three large institutions.

Valuing individual components of the global surgical package

CMS is seeking public comment on potential methods of valuing the individual components of the global surgical package, including the procedure itself, and the pre- and postoperative care, including the follow-up care during postoperative days. CMS is particularly interested in stakeholder input regarding the overall accuracy of the values and descriptions of the component services within the global packages. For example, CMS seeks information from stakeholders on whether (both qualitatively and quantitatively) postoperative visits differ from other E/M services.

There are many issues to take into consideration as CMS plans to value the individual components of the global packages.

- **Physician work:** We urge CMS to collaborate with the RUC to evaluate physician work. We believe that the RUC is in the best position for surveying, vetting, and valuing these services.

In addition, for the reasons below, we also stress that CMS should not rely exclusively on the recent RAND report titled “Development of a Model for Validation of Work Relative Value Units for the Physician Fee Schedule” for a methodology for valuing physician work RVUs. This report investigated the feasibility, methodological issues, and limitations involved in developing a model for valuing physician services that uses data from existing databases independent of the current RUC valuation process.

- RAND stated that the results presented in its report should be considered exploratory analyses that examine the overall feasibility of the model and the sensitivity of the model results to alternative methodological approaches and assumptions. The report did not produce a completed validation model for physician work values.
- The report indicated that it should not be used beyond two limited applications: (1) to flag codes as potentially misvalued if the CMS and RAND model estimates are notably different; and (2) as an independent estimate of the work RVUs to consider when assessing a RUC recommendation.
- While the report attempts to remedy data issues, the lack of available external data makes the utility of the findings limited. Specifically, the report states that there were no external databases with information on pre-service and immediate post-service times that could be used as a gold standard to build prediction models.
- The current RAND models contain methodological inconsistencies that make them impossible to use consistently across all codes. For example, the report acknowledges that the methods sometimes resulted in negative or implausibly low intra-service work. Most importantly the results of the RAND analysis do not provide a reliable and reproducible mechanism to maintain values that are relative across all CPT codes.
- The RAND methodology focuses only on surgical procedures and excludes E/M visits from the models. The report does not provide a rationale for excluding E/M services, but states that significant effort will be necessary to develop new models for the nonsurgical aspects of the resource-based relative value scale. We are concerned that excluding E/M codes from the model is a fatal flaw to the RAND methodology and results because E/M codes make up a significant proportion of Medicare spending. Thus, maintaining a fair relativity across all CPT codes is not possible using this methodology.

As such, we do not believe the RAND models described in the report should be used for valuing physician work.

- **Practice expense:** As CMS values the procedure itself, separate from the global code, the agency should incorporate the PE value that is unique to follow up visits in the base or “parent” code. This will prevent an unfair devaluation of the cost of supplies, labor, and equipment that is consumed in caring for the Medicare patient in the post-operative outpatient visits. CMS has previously stated that a disparity exists between E/M visits included in global surgical work and E/M visits that are discrete. Based on our analysis, the PE in separately reportable E/Ms is insufficient to account for the specialized supplies, equipment, and labor required for post-operative E/M care. The E/M services performed in a surgical global period often include additional and more expensive supplies and equipment relative to standard, separately reported E/M services. Examples of supplies that fall into this category are specialized bandages and dressings, staple and suture removal kits, and different postoperative incision care packs. Examples of equipment that fall into this category include specialized examination tables, cast cutters, surgical and exam lights, ultrasound units, and endoscopy equipment. Certain surgical E/M services also include additional clinical staff time relative to the clinical staff time for separately reported E/M visits. Examples include the additional clinical labor time required to care for stomas or for the setup and cleaning of scope equipment required at a post-op visit.

In addition, there are a number of post-operative services included in 10- and 90-day global codes that cannot be reimbursed using the current separately billable E/M codes. These post-operative services represent real dollar cost outlays by surgeons, both for supplies as well as labor, that are fairly paid for using the existing methodology in the 10- and 90- day global codes, but would be unpaid if surgeons were left to bill for them by using E/M codes. Examples of these services are listed in the Medicare Claims Processing Manual and include items such as: dressing changes; local incision care; removal of operative packing; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters; routine peripheral intravenous lines; nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

- **Malpractice:** In valuing the individual components of a global service separately, it is important that CMS prevent potential artificial reductions in professional liability insurance (PLI) RVUs for some specialties. The PLI RVUs for each service are calculated by multiplying the work RVU by the specialty risk factor of the specialty or specialties that perform the service. Currently, the work RVUs of the proxy E/M services contained in the global period for 10- and 90-day global codes are part of the PLI calculation. If the surgical procedure component is valued alone, CMS should not allow the surgical risk payment that is currently included in a 90-day global period to be removed and transferred to a diluted pool of non-surgical risk E/Ms. Similar to the PE formula, the PLI RVU formula was designed for a system where different global periods existed, and discrete services with high liability costs were delivered as part of the 90-day global surgical package. Any changes to how the E/Ms are included as part of the 10-and 90-day global periods would necessitate CMS reexamining how PLI is calculated and allocated for the surgical procedure. This may involve increasing the amount of recognized PLI for the remaining 0-day global service to ensure that surgeons are held harmless. We urge CMS not to use a methodology that redistributes the PLI associated with the global period to other specialties. A revised PLI formula should also properly and fairly credit resource-based specialty PLI costs to each specialty proportional to their own unique PLI costs.

Overall Accuracy

CMS also is interested in stakeholder input regarding the overall accuracy of the values and descriptions of the component services within the global packages. For example, CMS seeks

information from stakeholders on whether postoperative visits differ from other E/M services (both qualitatively and quantitatively).

Postoperative visits that are valued in global codes differ substantially from other E/M services.

As described above, there could be direct PE in the form of specialized supplies, equipment, and labor that are included in postoperative visits, but not in separately reportable E/Ms. Additional examples include:

- Cardiac surgery post-surgical office visits require RN staff-type
- Ophthalmology post-surgical office visits require COMT/COT/RN/CST staff-type
- Otolaryngology post-surgical office visits require suction machines, reclining chairs, loupes, or operating microscopes

Another issue related to the accuracy of global services is the application of the multiple procedure payment reduction policy. This policy applies to multiple surgeries performed by a single physician or same group practice on the same patient at the same operative session or on the same day. The MPPR pays at 100 percent of the fee schedule amount for the highest valued procedure, 50 percent for the second highest valued procedure, 25 percent for the third through fifth highest valued procedures, and “by report” for six or more procedures. The vast majority of the efficiency between multiple surgeries is due to the overlap of bundled E/M services between the surgeries. **Continuing to apply the same reduction percentage to the procedure component of the 10- and 90-day global code alone would inappropriately reduce the payment for second and subsequent surgical services.**

Other items and services

CMS is also interested in stakeholder input on what other items and services related to the surgery, aside from postoperative visits, are furnished to beneficiaries during post-operative care. As the practice of medicine evolves and CMS recognizes codes to capture collaboration of care for other specialties, we urge CMS to also recognize the collaborative work performed by surgeons (such as extensive collaboration with primary care), which is not captured in the global surgical package. As an example, if a patient were referred to a surgeon for colon or rectal cancer, the surgeon, for the majority of these patients, coordinates radiation and medical oncology appointments, coordinates preoperative imaging, and arranges for the patient to be presented to the Multidisciplinary Tumor Board after all imaging is performed. The surgeon explains all the images and laboratory tests and the intended therapy for the colon surgery and the timing of surgery after neoadjuvant therapy for rectal cancer. The surgeon also coordinates with a stomal therapy nurse, who is employed by the hospital, to meet with the patient and discuss management of an ostomy. Post-operatively, the surgeon works closely with the case manager for home health to discuss wound care and, if required, ostomy care with nursing visits and physical therapy. The surgeon also coordinates with the medical oncologist to ensure that patients follow up with that specialist. This is just one example of a case where a surgeon would provide a substantial amount of collaborative care that is not valued in the global surgical package. **We urge CMS to acknowledge this extra work that surgeons provide and to consider ways to include this work in the global code.**

As described in the example above, surgeons also perform transitional care management (TCM); however, TCM codes (99495 and 99496) cannot be billed in combination with a global code. **We urge CMS to allow surgeons to report 99495 and 99496 along with a global procedure when appropriate transitional care is delivered to the Medicare patient, as a way to properly and fairly account for this additional work.** In addition to collaborative care and transitional care, surgeons engage in advance care planning, which is not included in global codes. When a surgeon discusses a potential major surgical procedure with a patient prior to surgery or discusses the results following

surgery within the global period (for example if a non-resectable tumor was found during surgery), there is a strong likelihood that the conversation will include advance care planning and advance directives, so we ask that these services be allowed to be billed in conjunction with global procedures, when appropriate and documented.”

ACS Meeting on Global Codes 2016

“Overarching Recommendations

We start with a few overarching thoughts for the Centers for Medicare & Medicaid Services (CMS) to consider while evaluating the various factors affecting this policy. First, we understand that CMS has a time-sensitive legislative mandate to collect data, and we appreciate that it is a challenge for CMS to create a new data collection system while also ensuring that the data collected accurately reflect the care delivered by providers in the global period.

Second, the mission of the ACS is to put patient welfare above all else. We ask that CMS view these and other policy changes through the lens of potential impacts on patients by focusing on avoidance of any harm to patients. We also ask that CMS carefully consider negative and possible unintended consequences of any proposed methods of data collection. Hence, we urge CMS to choose options that pose the least administrative burden on physicians and their associated practice management and billing systems. We ask that CMS work to limit the unintended negative effects associated with some potential methods of data capture that may result in claims denials, unnecessary increased work for the physician, or any other disincentives to care for Medicare beneficiaries due to the complexities of the data collection process.

Third, we recommend that CMS implement this policy slowly, using small steps in the beginning, so as to better detect and mitigate these potential negative impacts and also to identify errors in the collected data. The time period where medical societies and CMS can properly educate their members to collect accurate data is very short (early November – late December 2016). As such, we recommend that any data collection process be instituted in measured and reasonable stages, rather than calling for physicians to comply with excessive new requirements starting on January 1, 2017. We recommend that CMS focus the initial data collection on just the number and level of postoperative visits rather than services provided in the entire global period. We suggest that CMS initially focus on refining the data collection process to obtain accurate and valid data on physician work rather than adding in additional complexity and potential errors by also attempting data collection on practice expense and malpractice.

Below we provide more detailed comments and suggestions on four aspects of the implementation of the data collection component of this policy: (1) whom CMS will collect data from; (2) what codes CMS will focus on; (3) how CMS will go about collecting data; and (4) how to engage surgeons to participate in the data collection.

Whom Data are Collected From

MACRA requires CMS to collect data from a representative sample of physicians. We do not believe that CMS should collect data from all physicians who bill 10 and 90-day global codes as this will increase the complexity and work involved with collection and analysis of the data. Instead, we urge CMS to choose the smallest number of physicians for data collection to ensure that the group is representative, but also minimizes the reporting burden for the physicians that are required to report. In other words, CMS should balance the need for a sufficiently broad sample that will provide data validity with the need to minimize the administrative burden on physicians. It will not be possible to obtain fair, accurate, and valid information that is representative of services delivered to patients across

our country from a single data source or even two or three large institutions. Some criteria that we consider helpful in determining whether a sample of physicians is truly representative are geography, population density, practice organizational settings, size of practice, teaching versus non-teaching environments, and specialties that provide the service.

What Data are Collected

MACRA requires CMS to obtain information needed to value surgical services and states that the collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery, as appropriate. As CMS begins to implement this policy, we recommend that the agency focus on just the post-operative visits instead of collecting data on the entire global period. We also urge CMS to initially focus on data collection for physician work rather than practice expense or malpractice.

We also suggest that CMS not collect data on *all* the codes that physicians who are selected as part of the representative sample of physicians bill; rather we recommend that CMS select both 10- and 90-day “anchor codes” for 2017. Anchor codes would include the following criteria:

- Relatively homogenous or uniform
- Have a 010 or 090 global assignment with at least one post-operative visit
- Have more than 10,000 claims or more than \$10,000,000 in allowed charges
- Exclude codes that are on CMS’ “potentially misvalued” list

How CMS will Collect Data

MACRA states that the data to be collected must be reported on claims, but can also be reported in another manner specified by the Secretary. MACRA does not establish a mechanism by which the data should be reported on claims. For the beginning stages of data collection, we support the submission of data using claims from a representative sample of physicians as opposed to some other mechanism. We do not know of a more effective way, starting in 2017, to collect these data.

Our key concern with any claims-based data collection mechanism is ensuring that the practice management software/billing system that physicians and their practices use can accommodate the new codes, modifiers, or other changes that will be needed in time to start collecting the data on January 1, 2017. We believe that CMS should take into consideration the challenges of accurate data collection. Some systems have “scrubbers” that will not process codes that are priced at \$0 or that are not otherwise recognized. The result of these claims scrubbers could be to strip off the additional claims data regarding the postoperative visits but allow the index procedure claim to go through, thus resulting in erroneous data for the work actually delivered by the physician in the post-operative period. In addition, such software is far from uniform across physician practices, and the internal mechanisms used to adjudicate claims are largely unknown. Hence, the CMS requirements and method for data collection must be generalizable as well as easily adaptable by the various software vendors. To help assist in achieving accuracy, we also ask that CMS include a feedback loop or some means for notifying physicians what data CMS has received, so that the errors in data received by CMS can be identified.

Our other concern revolves around the need for proper education of physicians and their staff on how to report work delivered by the physician in the postoperative global period. Proper education will be essential so that data reported are accurate. Given the short time frame, it will be difficult to inform physicians and their staff about how to submit data, regardless of what mechanism is chosen. Thus, selection of a mechanism for capturing and reporting of these data that most closely mimics the current

system of Current Procedural Terminology (CPT) code reporting will be the easiest to both implement as well as educate the physicians and staff members.

We describe some possible approaches to claims-based data collection on the number and level of post-operative visits. Each of these approaches has strengths and weaknesses, but their overall feasibility will depend on the capability of practice management software to incorporate the required changes and accurately transmit the data to CMS.

Existing E/Ms + modifier

Our preferred option for tracking the number and level of post-operative visits for the selected anchor codes is for the physician to submit the E/M code that would have been associated with that post-operative visit if it were separately billable, in combination with a modifier to indicate that the E/M is being reported only for data collection and not submitted for payment. The key advantage to this method is that for the past 20 years, CMS has helped develop and physicians have subsequently used this method (i.e., reporting of E/M codes for E/M visits). The values, method of use, and important guidelines for selection of the appropriate E/M codes have been through many reviews and refinements by both the American Medication Association/Specialty Society Relative Value Scale Update Committee (AMA RUC) as well as CMS. Thus, physicians already understand how to correctly submit E/M codes for each applicable level and setting.

For the claims submission and audit process, the documentation guidelines for E/M codes are well disseminated and understood by Medicare providers, coders, and compliance personnel, as well as others involved. These codes have the additional advantage of already being recognized by practice management billing software, and are now being submitted with modifiers -24 and -25 for E/M services provided in the global period for other medical reasons. Lastly, from the standpoint of accurate data analysis and ease of interpretation of the data by CMS, it will be important to choose a system that can be easily interpreted, interpolated, and correlated to the existing data in the AMA RUC database and CMS submitted claims files. Using the existing E/M codes with a modifier offers many advantages, compared to other solutions. Overall, we believe this approach would pose the least administrative burden from the standpoint of education, collection, and reporting; offer the lowest error rate in reporting; and would allow for the easiest meaningful interpretation by CMS of the gathered data.

99024 + modifier

Another possible option would be for the representative sample of physicians to submit CPT code 99024 plus a modifier for each post-operative visit associated with an anchor code. The 99024 would track the number of postoperative visits and the modifier would report the level of the visits. For example, physicians could submit 99024-V1 for a level 1 post-operative visit or 99024-V2 for a level 2 post-operative visit. The advantage to this approach is that, although not required for reimbursement of a 10- or 90-day global service, many physicians are familiar with reporting 99024 and many practices, practice management software systems, and EHR systems require that 99024 be submitted with post-operative visits. However, it would be essential that standards be established that clearly outline how to properly document and code these new “levels of codes,” similar to the documentation guidelines for E/M codes. This option could also be a less administratively burdensome approach, but it is unclear whether the currently used practice management software would require upgrades to process these claims if a modifier is also included and whether such upgrades are realistically feasible by January 1, 2017.

Reporting the primary CPT code twice

A third possible option is for physicians to continue to submit claims for the 10- or 90-day procedures that they normally bill, but to submit a second claim at the end of the 10- or 90-day period (or within a grace period) for the selected anchor codes. The second claim would include the CPT code associated with the 10- or 90-day anchor code along with a modifier to prevent the second claim from resulting in the physician billing for a single procedure twice. The second claim would also include a note attesting to the number and level of post-operative visits associated with that procedure. Many practice management systems have an “information” line that can be used to provide details such as the number and level of visits. This approach would be closely linked to the index case but would require significantly more post-data submission analysis by CMS since the text provided in the information will be free-style. We believe that this is a less-viable option, contingent on whether practice management software, billing systems, and CMS can accurately handle this process. In addition, this would require much more education and administrative burden on provider’s practices.

G-codes

A fourth possible option is for CMS to create a set of G-codes to track postoperative E/M visit data. There could be any number of G-codes created to cover the various combinations of number/level of visits across all possible sites of service. One possible advantage to the use of G-codes is that they will be new codes, so the practice management systems might not be already programmed to scrub them from claims. On the other hand, the downside to using brand new codes is that it could be more problematic to notify physicians about them before January 1, 2017, compared to the first two options discussed above. We consider G-codes an unnecessary duplication of current E/M visit codes that would require a significant educational effort, code definitions, and standards clearly detailing how and when to use a given G-code in relationship to the work provided in the global period. Assuming that the number and description of G-codes were different from the existing E/M codes for each applicable level and setting, an added layer of complexity would include CMS’ interpretation of the collected data in comparison to the existing data in the AMA RUC and CMS submitted claims files.

How to engage physicians to comply

ACS and CMS are both major stakeholders committed to improving the healthcare delivery system for surgical patients. Physician engagement will likely enhance the validity of the data collected, but there are challenges for maximizing physician engagement, namely, the short window to educate physicians about what and how to report and to adjust their office billing software and processes. Thus, selection of a methodology that is simple, straightforward, and similar to existing coding processes will be essential for the success of this program and to avoid choices that would force physicians to potentially take time away from actual patient care.

MACRA authorizes CMS to delay up to 5 percent of the physician fee schedule payment for services, for which a physician is required to report information, until the required information is reported. Given that there will be such a short time frame to inform physicians of the data collection mechanism, we urge CMS not to impose any penalties in 2017. It is also possible that there could be kinks or unexpected impediments to work out. As such, in the alternative to a delay in enforcing penalties we ask that CMS refrain from incorporating any penalties until it is clear that the systems are prepared, that there is evidence that physicians understand the requirements, that the data transmission is working smoothly, and that CMS is collecting the required data.

If CMS plans to utilize its authority to implement a penalty, we ask that it be applied in limited situations. In cases where CMS does not receive the required data from physicians, we ask that physicians receive a warning that they were required to submit data and a cautioning that their payment will be withheld if they do not comply. The ACS is willing to work with CMS to ensure that there is

more than adequate education for physicians about the data collection and ensure an appropriate warning system before the withhold is applied. We also urge CMS to include an exceptional circumstances clause for fire, flood, natural disaster, act of God, or other reason why complying with the reporting requirements would not be possible.”

MPFS 2018

“Collecting Data on Resources Used in Furnishing Global Services

Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to use rulemaking to obtain information needed to value surgical services from a representative sample of physicians. MACRA requires that CMS begin the data collection no later than January 1, 2017. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery, as appropriate. Beginning in 2019, the information collected, along with any other available data, must be used to improve the accuracy of the valuation of surgical services.

In the CY 2017 PFS final rule, CMS set forth a global codes data collection policy consisting of three components: (1) claims-based data reporting; (2) a survey of practitioners; and (3) data collection from accountable care organizations (ACOs). For claims-based reporting, CMS finalized a policy whereby practitioners who are in groups of 10 or more and who are located in any of nine designated states would be required to report CPT code 99024 for every post-operative visit that they provide related to any of the 293 10- and 90-day global codes specified by CMS. This mandatory data collection began July 1, 2017. Additionally, few details are known about the other two components, namely, the survey of practitioners and data collection from ACOs. Although MACRA allows a 5 percent withhold in payment for those practitioners who fail to report, we appreciate that CMS has not implemented this penalty.

While not addressed in the CY 2018 PFS proposed rule, we restate below some of our concerns with the claims-based data reporting implementation and questions regarding how the collected data will be used. We also request more information regarding the global codes list for 2018 in addition to information on the survey of practitioners conducted by the RAND Corporation. We strongly urge that CMS not use data collected via the claims-based data collection methodology to revalue global codes starting in 2019. Without sufficient time, provider education on this policy, or a detailed plan for data validation, the data collected will be inherently flawed and of low statistical quality. It is not appropriate to use these data to revalue global codes, especially if CMS assigns values to some CPT codes using a methodology that is completely independent from the RUC process.

Claims-Based Data Reporting – Current Policy Implementation Hurdles

As the claims-based data reporting is in the early stages, we have not been able to gather enough feedback from our members on their experience with reporting the 99024 code for postoperative visits. Leading up to July 1 data collection start date, the issue on which we received the most questions related to the definition of a “practice.” For the purposes of postoperative data reporting, “practice” is defined not as practitioners sharing the same tax ID number (TIN) as CMS defines groups in all other cases of CMS reporting, but rather as practitioners sharing “business or financial operations, clinical facilities, records, or personnel.” Practices of 10 or more practitioners are required to report the postoperative CPT code 99024 to CMS via claims.

This definition has led to confusion for our members. For example, one ACS Fellow asked if he is required to report given that he is part of a two-person neurosurgical practice, yet operates at an ambulatory surgical center (ASC) with 19 other partners from multiple specialties. The facility is used

exclusively for procedures, such as no consultative services or postoperative care is provided by any of the physicians who practice there; postoperative care is furnished in the physicians' private offices. Surgical billing is carried out under different TINs, as the physicians who operate at the ASC are wholly independent practices with different staff and different specialties. The only connection this surgeon has with the other physicians is through the facility which bills the facility fee with a single, unique TIN. It does not appear that this surgeon should count as being part of a group practice with the other 19 physicians, but based on CMS' definition of "practice", they do in fact share a facility (albeit JUST for procedures and nothing else). We have submitted questions, starting in May 2017, to the email address (MACRA_Global_Surgery@cms.hhs.gov) provided during CMS calls on this topic and have followed up, but have still not received a response.

Given the level of confusion that CMS' definition of "practice" has created, in addition to the lack of response to our emailed questions, we believe that CMS has severely undermined the integrity of the data that it intends to collect and should issue an immediate withdrawal of the requirement. MACRA does require CMS to collect data on the number and level of postoperative visits, but CMS is not mandated to collect these data via claims. CMS has the ability to use a different method to fulfill the MACRA requirement. In the event that CMS continues to require reporting of 99024 in the specified scenarios, **we strongly urge the Agency to revise the definition of a "practice" to conform to the definition of a group as practitioners sharing a TIN, which is used in other cases of CMS reporting.** This definition is a bright-line rule, is more familiar and intuitive to practitioners, and avoids surgeons having to calculate "practice" under one methodology for this Medicare requirement and "group" using completely different definitions for other Medicare programs.

In early 2017, CMS posted the list of 293 10- and 90-day global codes to be reported starting July 1, 2017, based on the articulated frequency criteria. However, CMS made no attempt to discuss or update the list of codes in this proposed rule for 2018 to ensure that the list of codes continues to meet CMS' finalized criteria. We are now uncertain as to whether these are the same codes that practitioners should use for reporting in 2018. Again, we believe that these discrepancies have severely undermined the integrity of the data being collected. However, if CMS continues to require the reporting of 99024 in certain scenarios, **we ask that CMS clarify whether practitioners should use the 2017 list of high volume/high value 10- and 90-day global codes or whether CMS plans to release a new list for 2018 reporting.**

Claims-Based Data Reporting – Analysis and Use of Collected Data

We reiterate several logistical and policy questions on how CMS will analyze and use the data that are collected via the claims-based process. Specifically:

- How will CMS keep the appropriate 99024 code attached to the index procedure? This is especially important in cases where multiple CPT codes from the list of 293 codes are reported within the same global period.
- What process has CMS developed for providers to confirm that all 99024 codes they submitted have been captured?
- How will CMS confirm that data have been reported accurately?
- How will CMS handle the data from practitioners who do not consistently report 99024? Despite best efforts at education, some practitioners will not reliably report 99024 as required, most often because EMR systems between facilities and offices are not compatible. How will CMS take this into consideration?
- How will CMS handle procedures that are submitted with modifiers? There are a number of modifiers that are appended to surgery claims that impact the provision of postoperative care, which could significantly impact data collection.

With these questions unanswered, we do not believe it is appropriate for CMS to use data collected via the claims-based process to revalue codes in 2019. In addition, it is inappropriate to assign values to some CPT codes using a methodology that is completely independent from the magnitude estimation process used by Harvard and the RUC. **The RUC recommends work values for CPT codes based on their relativity to other CPT codes and not based on a sum of component services (e.g., the building block methodology), so attempting to assign values outside of this relative value scale for some, but not all, CPT codes would be improper and methodologically unsound.** This process disproportionately impacts some specialties, both in terms of administrative data collection burden and how the data will be used.

RAND Survey

We also have very little information regarding the survey of practitioners (the second component of global codes data collection). The CY 2017 PFS final rule stated that the survey will be in the field by mid-2017, yet we have no information about the survey to begin educating our members on what to expect. In addition, it is critical that clinical experts from the specialties who will be surveyed have the opportunity to review and provide feedback on the survey design, methodology, content, and data analyses. At this point, our understanding is that just one member from a selection of specialties will be interviewed and only those without payment expertise have been considered. We have many questions and concerns regarding the survey development and **we urge CMS not to move forward with this practitioner survey until it has been thoroughly vetted and the specialties to be surveyed have had an opportunity to review it and provide feedback.**”

MPFS 2019

“Update on Global Surgery Data Collection

As required by the Medicare Access and CHIP Reauthorization Act (MACRA), CMS implemented a process for collecting data on the number and level of post-op visits related to 10- and 90-day global codes. CMS provided several reporting statistics in the proposed rule from states where reporting was required. Of the clinicians who were required to report CPT code 99024 for post-operative visits based on the policy effective July 1, 2017, only 45 percent reported one or more visits during the first six-month period ending December 31, 2017. Among 10-day global procedures performed in that window, only 4 percent had one or more matched visits reported with CPT code 99024. CMS indicated that it is possible that clinicians are not consistently reporting post-operative visits but did not rule out the possibility that post-operative visits are not being provided if not reported, especially in the case of 10-day global procedures.

The ACS and a number of other surgical specialty societies worked diligently to inform our members of the global codes data collection reporting requirements leading up to July 1, 2017 and afterwards. Despite our best efforts, however, it is highly unlikely that all clinicians who are required to report are doing so for every post-operative visit for every procedure. Anything short of perfect reporting will result in inaccurate data that should not be used to revalue global codes. We believe that CMS has met the MACRA requirements to collect data on the number of post-operative visits. CMS has indicated that it will soon be surveying three additional codes for data related to the level of visits—we believe this will satisfy the data collection portion of the law. MACRA also requires that CMS “improve the accuracy” of global codes based on the data that are collected or other available data. **The College does not believe that the data that have been collected can be used to improve the accuracy of the existing codes, and we urge CMS not to proceed with revaluing global codes at this time.**”

“Global Surgical Packages

CMS does not propose to use the RUC-recommended values for E/M visits to adjust the office/outpatient E/M visits that are bundled into global code payment. CMS does not provide a clear rationale in the proposed rule for holding back from taking this step, but when asked at the MPFS briefing hosted by the AMA on August 13, CMS representatives stated that the Agency was mandated by MACRA Section 523 to use data that have been collected to revise the values of global codes. As part of MACRA, Congress requires CMS to develop a process to gather information to value surgical services from a representative sample of physicians and required that the data collection begin no later than July 1, 2017. MACRA also required that, beginning in CY 2019, CMS must use the information collected as appropriate, in addition to other available data for improving the accuracy of valuation of surgical services under the PFS. CMS also directs stakeholders to review three reports produced by its contractor, RAND Corporation, and to consider alternative ways to address the values for these services.

Lack of Inclusion of RUC-Recommended E/M Values in Global Code Payment

As we stated in our comment letter to CMS, dated August 15, 2019, co-signed by 53 organizations, we are strongly opposed to CMS failing to incorporate into the global codes the adjusted values for the revised office/outpatient E/M codes. By failing to adopt all of the RUC-recommended work and time values for the revised office visit E/M codes for CY 2021, including the recommended adjustments to the 10- and 90-day global codes, CMS improperly proposes to implement these values in an arbitrary and piecemeal fashion. If CMS plans to move forward with the proposal to adopt the RUC-recommended values and times for office/outpatient E/M codes, it is inappropriate to not also apply the incremental RUC-recommended changes to global codes. If CMS finalizes the proposal to adjust the office/outpatient E/M code values, the agency must apply these updated values to the global codes. It is imperative that CMS take this crucial action because to do otherwise will:

- Disrupt the relativity in the fee schedule: Applying the RUC-recommended E/M values to stand-alone E/Ms, but not to the E/Ms that are included in the global surgical package since the inception of the fee schedule, will result in disrupting the relativity between codes across the Medicare physician fee schedule. Changing the values for some E/M services, but not for others, disrupts this relativity, which was mandated by Congress, established in 1992, and refined over the past 27 years. Indeed, since the inception of the fee schedule, E/M codes have been revalued three times—in 1997 (after the first five-year review), in 2007 (after the third five-year review) and in 2011 (after CMS eliminated consult codes and moved work RVUs into the office visit codes). When the payments for office visit codes were increased in these instances, CMS also increased the bundled payments and time for office visits in the global codes. This was in recognition of the fact that the Harvard study set relativity of all procedures and services when the first PFS was implemented.
- Create specialty differentials: Per the Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the “Secretary may not vary the...number of relative value units for a physicians’ service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.” Failing to adjust the global codes is tantamount to paying some physicians less for providing the same E/M services, in violation of the law. Again, the Harvard study set relativity of all procedures and services when the first PFS was implemented. The E/M codes were studied and valued and the global codes were developed using the same E/M visit intensity.

- Run afoul of section 523(a) of MACRA: CMS points to the ongoing global code data collection effort as a reason for not applying the RUC-recommended changes to office/outpatient E/M codes to global codes. In addition, the Agency states that it is required to update global code values based on objective data on all of the resources used to furnish the services included in the global package. These arguments conflate two separate issues. The issue that CMS raises regarding MACRA legislation is not related to maintaining relativity across the fee schedule based on current data in the CMS work/time file. In fact, Section 523(a) specifically authorizes CMS to make adjustments to surgical services, notwithstanding the mandate to concomitantly undertake the MACRA-mandated global code data collection project.
- Ignore recommendations endorsed by nearly all medical specialties: The RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full increase of work and physician time for office visits be incorporated into the global periods for each CPT code with a global period of 10-days, 90-days and MMM (maternity). The RUC also recommended that the practice expense inputs should be modified for the office visits within the global periods.

Again, if CMS moves forward with accepting the RUC-recommended values and time for office/outpatient E/M codes, we strongly urge CMS not to finalize a policy that fails to apply these same RUC-recommended changes to both stand-alone office visit E/M codes and the office visit E/M component of the global codes.

RAND Reports

CMS contracted with RAND to collect and analyze data as part of the MACRA mandate. RAND describes its findings in three reports, which we comment on in below.

RAND Report #1: Claims-Based Reporting of Post-Operative Visits for Procedures with 10- or 90-Day Global Periods

Beginning July 1, 2017, CMS required practitioners in groups of 10 or more, practicing in nine specified states, to report code 99024 for each postoperative visit after select procedures with 10- and 90-day global periods in order to collect data on the number of postoperative visits that were provided associated with those global services. This RAND report analyzes Medicare claims data (and reported 99024 codes) for procedures furnished between July 1, 2017 and June 30, 2018. The key findings include:

- Postoperative visits reported:
 - When examining single, non-overlapping procedures linked to postoperative visits, RAND found that 3.7 percent of 10-day global periods had one or more postoperative visits reported.
 - When examining single, non-overlapping procedures linked to postoperative visits, RAND found that 70.9 percent of 90-day global periods had one or more postoperative visits reported.
- Reported visits compared with expected:
 - The ratio of observed to expected postoperative visits provided with 10-day global periods was 0.04.

- The ratio of observed to expected postoperative visits provided with 90-day procedures was 0.39.
- To address concerns of underreporting, RAND performed a sensitivity analysis of practitioners who appeared to be actively engaged in reporting postoperative care (“robust reporters”), and found moderately higher rates of postoperative visits that were still lower than expected.

While we have a number of questions about the RAND analysis, we are most concerned about the CMS data collection process. There is no way to confirm that the data reported through this program accurately represent the patterns of postoperative visits and care provided after 10- and 90-day global procedures. Therefore, absent a way to verify the validity of the data, it is not possible to verify the validity of the report’s conclusions. The data collection process was flawed for multiple reasons, including:

- Lack of adequate notice/education: CMS did very little outreach to physicians on the requirement to report 99024 code data. Many specialty societies worked diligently to inform their members of the new reporting requirement, but we strongly believe that a large percentage of physicians who were required to report simply could not be adequately informed. We are aware of only a few of our members receiving a single and somewhat ambiguous letter from CMS on this issue and the need to report after the reporting period had already begun.
- Definition of “practice”: CMS required physicians in practices of 10 or more to report postoperative visit data; however, a “practice” was defined not as practitioners sharing the same tax ID number (TIN) as CMS defines groups in all other cases of CMS reporting, but rather, as those who share “business or financial operations, clinical facilities, records, or personnel.” This broad definition of “practice” was difficult to explain to physicians and created considerable confusion about who was required to report.
- Need for near perfect reporting: In order to draw valid conclusions on the number of postoperative visits provided, near perfect reporting would be required. Statistical analyses exist to account for small amounts of under- or over-reporting, but attempting to obtain accurate results presumes that almost all expected reporters are reporting almost perfectly most of the time. Without a way to confirm this assumption, it would not be valid to assume that the collected data are accurate. Not only is this confirmation lacking, but we have received feedback from surgeon leaders in some of the 9 states that attempts to submit data were met with difficulties due to claims scrubber programs that may have resulted in failure to report.
- Confirmation of reported 99024 claims: Despite repeated requests from stakeholders, CMS did not establish a process by which practitioners could confirm that CMS received submitted claims for reported 99024 codes. The need for confirmation is critical given the numerous hurdles for reporting. These include required updates to practice management software and updates to code scrubbing protocols in the claims clearinghouses to allow transmission of claims for 99024 to CMS, but not to other commercial payers or to self-pay patients. Without some form of feedback, it is impossible for physicians to know whether or not the 99024 codes that they attempted to report were actually transmitted and received. Therefore it is very possible that the collected data are not accurate.

We also have a number of concerns with RAND’s analysis:

- Definition of “practice”: As described above, CMS defined a “practice” as those who share “business or financial operations, clinical facilities, records, or personnel.” RAND, however,

defined practice by TIN. We appreciate that RAND recognized the confusion surrounding this definition, and we agree that use of the TIN is a better proxy for group size compared to the CMS definition. However, we received many questions that highlighted the deep confusion and lack of understanding of the CMS definition of “practice” for purposes of reporting. Even if RAND now uses the TIN as a measure instead for analysis, the confusing definition of “practice,” at the time when physicians were determining whether they should report could have deterred some who were part of a TIN of 10 or more clinicians from actually reporting, thereby contributing to underreporting. So our concerns remain regarding whether all the required reporters were adequately informed that they were in fact required reporters, even if retrospectively the group size is evaluated based on the TIN.

- **“Clean” procedures:** Because patients may undergo multiple procedures on the same day or over a short period of time, the analysis was limited to “clean” procedures, defined as billed procedures with 1 billed unit of service, that do not overlap with the 10 or 90-day global period for any of the patient’s other procedures. This method was used as a method to link a given procedure and postoperative visit unambiguously. An *Annals of Surgery* article states that “...Among the 293 procedure codes, 60.83% of procedures with 10-day global periods and 59.99% of procedures with 90-day global periods were clean.” It is not clear, but we assume this means that approximately 40 percent of possible records were not included in the analyses. This is a significant limitation and represents a possible bias toward less complicated operations.
- **Sensitivity analysis:** The report acknowledges that the results showing fewer postoperative visits than expected could be due to underreporting. As such, the methodology includes a sensitivity analysis whereby the results were compared to a subset of physicians defined as “robust reporters.” These physicians were found to have performed 10 or more procedures with 90-day global periods and reported at least 1 claim for a postoperative visit for at least half of the procedures performed beginning July 1, 2017. The article does not explain why a “robust reporter” is defined as only reporting 1 postoperative visit for half of the procedures performed, which is a tiny fraction of the expected number under the current valuation of global codes. For the robust reporters, if the data are not capturing 100 percent of the claims (either because the code is not being reported for all procedures as expected or because submitted codes were not being received/processed by CMS) then that means even for robust reporters up to half of the postoperative visits were not being captured (i.e., the results of this study would be underestimating the proportion of postoperative visits by half). Also, this definition of “robust reporters” would include many reporters that joined late, believed they only needed to report once for each code, or for some reason stopped reporting. There is no way to be certain these partial reporters were not excluded from being grouped as “robust reporters”. The analysis also compared data from “high volume reporters,” defined as those who billed 10 or more procedures with 90-day global periods. But the article does not explain whether high volume reporters reported any 99024 codes at all or whether there was any connection between providing more 90-day services and more accurately reporting the associated 99024 codes. Therefore, we are not confident that the sensitivity analysis accounts for the concerns about skewed data caused by underreporting.
- **Underreporting:** We are alarmed by the conclusion in the *Annals of Surgery* article that, “...underreporting is unlikely to fully explain the low proportion of expected postoperative visits provided. In subanalysis limited to surgeons who were actively reporting their postoperative visits, the patterns were largely similar, suggesting that a large share of expected postoperative visits are not delivered.” This statement presumes that data reported by those physicians defined as “actively reporting” are reflective of the actual number of postoperative visits provided. But these physicians

count as “robust reporters” if they were found to have performed 10 or more procedures with 90-day global periods and reported at least 1 claim for a postoperative visit for at least half of the procedures, which is much less than the expected number of postoperative visits. Similarly, it does not provide any substantiation that these physicians were reporting 99024 for all the postoperative visits that they provided, nor does it provide substantiation that claims submitted by the physician were received.

- Inclusion of non-reporters: In a briefing with RAND organized by the AMA on August 13, the authors of the report indicated that when calculating the ratio of observed to expected postoperative visits for both 10- and 90-day global procedures, physicians who could have reported, but did not report, were considered to have reported no visits. To conclude that those who did not report were affirmatively reporting that they did not provide any visits related to the global procedures is inappropriate since there is no way to know with certainty whether no visits were provided or whether some other reason (lack of knowledge of reporting requirements, problems with practice management systems, issues with clearinghouses, etc.) prevented the providers from reporting instead. This is especially concerning given that only 46 percent of providers expected to participate submitted tracking code 99024 for the 1-year period on which the report was based (i.e., more than 50 percent of providers expected to report were erroneously assumed to never perform a postoperative visit). In addition, only 17 percent of physicians were classified as “robust reporters,” meaning that the majority of those who reported did not even submit 1 claim for a postoperative visit for at least half of the procedures performed in the measurement period.
- 10-day global period: There are many instances in which postoperative visits that are related to a 10-day global service are performed outside of the 10-day period (for example, on day 14). In the August 13 briefing with RAND, attendees asked whether RAND investigated and/or were able to confirm whether postoperative visits for codes with a 10-day global period that were performed outside the 10-day global period were tracked in some way. These postoperative visits could have been either not reported with a discrete E/M or reported with 99024 instead. For example, there are many instances where minor surgery is performed on tension-sensitive areas and sutures may be retained for more than 10 days. RAND could not confirm if this was a pattern that was missed in their analysis. We believe that many providers have recognized that if a postoperative visit were required related to a 10-day global procedure, for example to remove sutures, that they could not separately report that service even if the visit were outside of the 10-day window.

Given the high degree of ambiguity related to the CMS data collection process and the concerns about the methodology that RAND used to analyze the data, the authors' conclusions about the results are not valid and it is not appropriate to make a recommendation to reassess payment for surgical procedures based on these flawed data.

RAND Report #2: Survey-Based Reporting of Post-Operative Visits for Select Procedures with 10- or 90-Day Global Periods

Per MACRA, Congress directed CMS to collect data on the number and level of postoperative visits during the global period. The required reporting of CPT code 99024, as described above, was in response to the mandate to collect data on the number of visits. In order to collect data on the level of visits, RAND developed a survey to collect data on the types of care provided in postoperative visits for three procedures: cataract surgery, hip arthroplasty, and complex wound repair. The key findings related to time and work, where CMS compared reported physician time and work to physician time and work implied by the E/M visits considered by CMS when valuing the procedures as listed in the Physician Time File.

RAND found that:

- Reported physician time and work were generally similar, but slightly less, than Physician Time File levels for cataract surgery and hip replacement.
- Reported physician time and work were higher than expected from the Physician Time File for complex wound repair.

We question why RAND does not consider staff time as contributing to the level of the visit, and instead considers this time purely as part of PE in the RUC process. In cases where QHPs bill “incident-to” physician services or even separately report Medicare services, both the work of the physician and the QHPs combined time is used to select the level of the visit. **If CMS uses this information to inform further discussion, the QHP time should be taken into consideration as well when assessing the time for these and other global codes.**

RAND Report #3: Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- and 90-day Global Periods

In this report, RAND uses the claims-based data on the number of postoperative visits to adjust valuation for procedures with 10- and 90-day global periods. To provide estimates to frame the discussion of revising payment for global services, RAND revalued procedures by adjusting work RVUs, physician time, and direct PE based on the difference between the number of postoperative visits observed via claims-based reporting and the expected number of postoperative visits used during revaluation (also known as the “reverse building block” approach). Their key findings include:

- Depending on which observed visit metric was used as an input in revaluation, the updated work RVUs were between 38 percent and 40 percent lower for procedures with 10-day global periods.
- Depending on which observed visit metric was used as an input in revaluation, the updated work RVUs were between 18 percent and 30 percent lower for procedures with 90-day global periods.
- The estimated change in Medicare payment for specialties (including an updated conversion factor), resulted in a range of updates from 3.0 percent to -18.4 percent. General surgery would receive an -11.8 percent payment cut.

The RAND report begins with the blanket assumption that procedures with 10-day and 90-day periods are overvalued, specifically, are valued as having too many RVUs. This assumption is based on the prior RAND studies. RAND uses the findings from the first report to apply the 4 percent observed vs. expected ratio from 111 10-day global services, for which reporting was required, and the 39 percent observed vs. expected ratio from 185 90-day global services, for which reporting was required, to all surgical global services (over 4,200 codes) using the reverse building block methodology. **For the reasons we described in our comments on the first report, above, it is not appropriate to use these flawed results to make recommendations on updated values for global services, let alone use the results themselves to calculate those recommendations.**

The first RAND report concludes with limitations of the analysis:

‘...we sought to address concerns about underreporting of post-operative visits by conducting subanalyses limited to practitioners who were actively reporting their post-operative visits. However, we recognize that reporting of post-operative visits for these practitioners also may not be complete. Moreover, we observed differences in the

characteristics of procedures performed by these robust reporters, and, as a result, their patterns of care may not be generalizable to the broader population of practitioners required to report post-operative visits.’

As stated in the first study, it is not appropriate to generalize the results of the first study to all practitioners required to report. **It is therefore far less appropriate to generalize the results of the first study to all specialties and all global services.**

RAND made several assumptions as part of this approach, one of which is that RAND assumes that bundled postoperative visits that were not observed did not occur. For the reasons we discussed above, **this is an incorrect assumption because there is no way to know with certainty that the visits that were not reported truly did not occur.**

RAND also used the median observed visits as a primary approach for analysis because medians are used elsewhere in the valuation process. The report does not describe where else in the valuation process the median observed visits are used for analysis. The RUC often uses the median values when utilizing survey results for making recommendations to CMS. But this approach is to correct for potential overreporting of time and work in survey responses. In contrast, overreporting is highly unlikely and would be quite difficult if not impossible when complying with the required reporting of code 99024 because physicians would have to intentionally report additional codes, and EHRs and practice management systems would likely prevent any instances of overreporting.

It is not appropriate to use flawed, incomplete, and inaccurate results to make recommendations on updated values for global services. Even if RAND’s analysis and methodology were sound, the conclusions cannot be relied upon if there is no certainty that the underlying data are valid.”

MPFS 2021

“Revaluing Services that are Analogous to Office/Outpatient E/M Visits

CMS noted in the CY 2020 PFS rule that it believes that there are services other than global surgical codes for which the values are closely tied to the values of the office/outpatient E/M visit codes because, according to the Agency, many services have E/M visits explicitly built into their definition or valuation. CMS reviewed some of these services, and we provide feedback on such review below.

As an overarching comment, all global codes with inherent E/M visits in the global period should be incrementally adjusted when the values and times for E/M services change. This policy should be applied to all global codes, regardless of whether the value of the code is based on magnitude estimation, building block methodology, or a mix of both. Specifically, the review of a global code using magnitude estimation includes an understanding that a certain number and level of E/M visits is inherent. Therefore, the incremental increases maintain relativity between global procedures and discrete E/M services, and also recognize that the compelling evidence for an increase in work to perform an E/M service is the same for codes based on a global period.

Global Services

General

CMS notes that while the RUC recommended values for 10- and 90-day global codes that incorporated the increased values of the office and outpatient E/Ms, it did not make changes to the valuation of the 10- and 90-day global surgical packages to reflect changes made to values for the office/outpatient E/M visit codes while the Agency continues to collect and analyze data on the number and level of office/outpatient E/M visits that are actually being performed as part of these services. **We reiterate**

that it is inappropriate for CMS to not apply the RUC-recommended changes to global codes starting in CY 2021. To do otherwise will:

- ***Disrupt the relativity in the fee schedule:*** Applying the RUC-recommended E/M value increases to stand-alone E/Ms, select global codes, and select bundled services—but not to the E/Ms that are included in the global surgical package—will result in the disruption of the existing relativity between codes across the Medicare PFS. Changing the values for some bundled services that include E/M services, but not for others, disrupts this relativity, which was mandated by Congress, established in 1992, and refined over the past 27 years. Indeed, since the inception of the fee schedule, E/M codes have been revalued three times: in 1997 (after the first five-year review), in 2007 (after the third five-year review), and in 2011 (after CMS eliminated consult codes and moved work RVUs into the office visit codes). When the payments for new and established office visits were increased in these instances, CMS also increased the bundled payments for these post-operative visits in the global period. **The Agency should apply a fair and consistent policy for all global codes, whether the value of the code is based on magnitude estimation, building block methodology, or a mix of both methodologies.**
- ***Create specialty differentials:*** Per Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the “Secretary may not vary the . . . number of relative value units for a physicians’ service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.” Failing to adjust the global codes is tantamount to paying some doctors less for providing the same E/M services, and thereby in violation of the law. In the CY 2021 PFS proposed rule, CMS points to the method of valuation (i.e., building block versus magnitude estimation) for a rationale as to why some bundled services should be increased in value to reflect the revised office/outpatient E/M values, while global codes should not. However, this statutory prohibition on paying physicians differently for the same work applies regardless of code valuation method. Therefore, the incremental increases should apply to the global codes.
- ***Inappropriately rely on section 523(a) of MACRA:*** In the CY 2021 PFS proposed rule, CMS refers to its decision in the CY 2020 PFS final rule to not make changes to the valuation of the 10- and 90-day global surgical packages to reflect the increased values for the office/outpatient E/M visit codes while the Agency continues to collect data on the number and level of post-operative visits included in global codes as required by MACRA. The MACRA data collection requirement, set forth in section 523(a), does not prohibit CMS from applying the RUC-recommended incremental increases to the office/outpatient E/Ms codes to global codes. In fact, section 523(a) specifically authorizes CMS to adjust surgical services, notwithstanding the mandate to concomitantly undertake the MACRA-mandated global code data collection project. In addition, it is inappropriate for CMS to rely on the implementation of MACRA, which became effective in 2015, as a reason to refrain from making necessary updates in 2021. This inaction punishes a subset of physicians who, like all healthcare practitioners, are experiencing the pressures of a global pandemic as well as steadily rising costs of labor and supplies necessary to maintain a viable and safe practice.
- ***Ignore recommendations endorsed by nearly all medical specialties:*** The RUC, which represents the entire medical profession, voted overwhelmingly (27-1) in 2019 to recommend that the full incremental increase of work and physician time for office visits be incorporated into the global periods for each CPT code with a global period of 10-day, 90-day, and MMM (maternity). The RUC also recommended that the practice expense inputs should be modified for the office visits within the global periods. In the CY 2021 PFS proposed rule, CMS is using the RUC

recommendation as part of the rationale for proposing to increase the values of the maternity services codes and select other bundled services, but then ignores the RUC's advice by not applying the same logic to the global bundled codes.

As we noted earlier under the "Revaluing Services Analogous to Office and Outpatient E/Ms" section of this comment letter, even the primary care global care management code values were based on magnitude estimation. Again, we strongly urge CMS to apply the RUC-recommended changes to the E/M component of the global codes in order to maintain the relativity of the fee schedule."

MFPS 2022

Office Visits Included in Codes with a Surgical Global Period

We continue to voice our disappointment that CMS has failed to incorporate the RUC-recommended work and time incremental increases for the revised office/outpatient visit E/M codes into the global codes. CMS has failed to address this issue in both the CY 2021 and CY 2022 MPFS rules. While CMS did finalize adjustments for other bundled services, such as maternity codes, in the CY 2021 MPFS, organized medicine has been united in its recommendations that CMS incorporate the incremental revised office/outpatient E/M values into all of the 10- and 90-day global surgical package codes, as evidenced by the many comment letters and meetings over the past several years.

The proposed 3.75 percent reduction to the CY 2022 conversion factor will further add to cuts that many physician specialties have been experiencing for years. **We reiterate that it is inappropriate for CMS not to apply the RUC-recommended changes to global codes.** To do otherwise will continue to:

- Disrupt the relativity in the fee schedule: Applying the RUC-recommended E/M value increases to stand-alone E/Ms, select global codes (e.g., monthly end-stage renal disease and bundled maternity care), and select bundled services (e.g., monthly psychiatric management), but not to the E/Ms that are included in the global surgical package will result in disrupting the relativity between codes across the MPFS, which was mandated by Congress, established in 1992, and refined over the past 27 years.

In 1991, a CPT revision of the E/M codes required Harvard and CMS to add work to global codes for the E/M. CMS assigned to the global codes what the Agency believed to be the equivalent to the work value for the discrete E/M codes. But then following this assignment, the work for the discrete E/Ms was increased slightly in the first fee schedule in 1992 and then increased again in 1993. These two changes by Harvard in 1991 and CMS in 1992 were never translated back to the global codes. So from the very beginning of the fee schedule, the postoperative E/M work relative value was discounted by 15-20 percent. The full value of the E/Ms has never been added back to global codes because the RUC doesn't use the BBM. But each time that E/Ms increased and CMS adjusted the global code values, only the incremental increase was applied, maintaining relativity. In summary, since the inception of the fee schedule, the E/Ms in the global codes have been discounted, but the original relativity has always been maintained. By not increasing the global by applying the incremental increase, the Agency has essentially established two separate fee schedules that are no longer relative.

- Create specialty differentials: Per Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the "Secretary may not vary the . . . number of relative value units for a physician's service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." Failing to adjust the global codes is tantamount

to paying some doctors less for providing the same E/M services, which is in violation of the law. In the CY 2021 MPFS proposed rule, CMS pointed to the method of valuation (i.e., building block vs. magnitude estimation) for a rationale as to why some bundled services should be increased in value to reflect the revised office/outpatient E/M values, while global codes should not. However, this statutory prohibition on paying physicians differently for the same work applies regardless of code valuation method and the incremental increases should apply to all physicians.

- Ignore recommendations endorsed by nearly all medical specialties: The RUC, which represents the entire medical profession, voted overwhelmingly (27-1) in 2019 to recommend that the full incremental increase of work and physician time for office visits be incorporated into the global periods for each CPT code with a global period of 10-day, 90-day, and MMM (maternity). The RUC also recommended that the practice expense inputs should be modified for the office visits within the global periods. In the CY 2021 MPFS, CMS used the RUC recommendation as part of the rationale for proposing to increase the values of the maternity services codes and select other bundled services, but not the global bundled codes.

Again, we strongly urge CMS to apply the RUC-recommended changes to the E/M component of the global codes to maintain the relativity of the fee schedule congruent with the revaluation of the office/outpatient E/Ms. While we believe the Agency should have made the adjustments to the globals in CY 2021 rulemaking rather than in CY 2022, we would highlight that it would not be without precedent to address the valuation of the global codes in the subsequent year. After changes were made as part of the first Five-Year Review of the MPFS, CMS (formerly the Health Care Financing Administration (HCFA)) initially declined to apply the E/M increases to the globals. However, the following year, in the CY 1998 MPFS final rule, the Agency directly stated, “Upon further examination of this issue, we are increasing the work RVUs for global surgical services to be consistent with the 1997 increases in the work RVUs for evaluation and management services.”¹⁵

As we have consistently held, it has been the Agency’s policy to make these changes to the global codes, and it would not be without precedent to make them in the year subsequent to the revaluation of the E/Ms. We implore the Agency to follow its own precedent and resolve this issue.”

American Society of Cataract and Refractive Surgery



AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY

President
Nick Mamalis, MD

Executive Director
Steve Speares

February 6, 2020

The Hon. Anna Eshoo
Chairwoman
Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
698 Emerson St.
Palo Alto, CA 94301

Dear Chairwoman Eshoo,

It was so nice to see you this week, even if it meant commiserating about the Super Bowl outcome. Thank you as well for taking the time to meet with me on behalf of the American Society of Cataract and Refractive Surgery (ASCRS). As requested, this letter outlines ASCRS' recommendations—and those of the surgical community at large—related to post-operative evaluation and management (E/M) services included in global surgery codes and the E/M add-on code. As we discussed, the Centers for Medicare and Medicaid Services' (CMS) 2021 finalized policies contain a significant flaw. This conflicts with current law and will unfairly cut Medicare payments to surgeons, particularly ophthalmologists.

Specifically, we ask that Congress take action to:

- Require CMS to apply the finalized 2021 office and outpatient evaluation and management (E/M) adjustments to the surgical codes with global periods in order to comply with the prohibition on specialty differentials established by Congress in the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239) for the same service; and
- Halt CMS' finalized policy to redistribute payments to certain specialties at the expense of others via an add-on code that was created with little data, rationale, or resource input.

E/M Global Code Policy Changes – Effective 2021

We discussed that E/M codes describe the length and complexity of clinic visits and are universally used for billing and payment. Charges and payment for surgery bundles together the

operation and all post-operative clinic visits during a global period after surgery (e.g. 90-days). If they were not bundled, the postop visits would each have an E/M code, but this is instead factored into the global payment for surgery. In the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (PFS) final rule published in November 2019, CMS increased the payment levels for stand-alone office and outpatient E/M codes effective 2021. However, CMS did not apply the payment adjustment to the corresponding E/M portion of the 10- and 90-day global surgical codes. Arbitrarily adjusting some E/M services but not others conflicts with OBRA, which prohibits Medicare from making Medicare payments to physicians for the same work but at different levels because of the physician's specialty. This is why every time standalone E/M visits have been increased in the past, the increase has also been applied to the global surgery codes.

Failing to apply the increased values of standalone E/M codes to global surgery codes unfairly penalizes all surgeons but is particularly problematic for cataract surgery because it was revalued and reduced effective 2020. Separately, in the 2020 PFS final rule, CMS finalized new reductions specifically in cataract surgery reimbursement following a recent revaluation by the American Medical Association's (AMA) Relative Value Update Committee (RUC). The revaluation and reduction were based on a survey conducted by ASCRS and the American Academy of Ophthalmology that found one fewer post-operative E/M visit was being furnished than included in the previous value. The 2020 cataract surgery code now reflects this lower number of post-operative E/M visits, which is three: two level 2 visits and one level 3 visit.

Regarding the flawed discrimination between standalone and postop E/M codes, CMS contends it cannot increase the value of post-operative global codes while it is conducting a study of the codes authorized under the Medicare Access and CHIP Reauthorization Act (MACRA). However, the 2020 revaluation of cataract surgery demonstrates that CMS can continue to update individual global code values, and that the RUC (AMA committee) is the appropriate venue for developing value recommendations. In fact, the MACRA statute explicitly instructs CMS to continue to update the individual codes while they are conducting the overall study. Given that CMS has so recently verified that cataract surgery includes three post-operative E/M services as part of its global code, those visits should be reimbursed at the same rate as standalone codes.

Add-on Code Policy Changes

In 2018, CMS proposed to restructure the coding system for office and outpatient E/M visits to reduce documentation burden by collapsing the payment levels. Because primary care would experience payment cuts, CMS proposed add-on codes to provide an additional payment specifically for primary care and certain specialty visits to minimize cuts associated with these code changes. These codes were created with little data, rationale or resource input. Ultimately, CMS didn't adopt the collapsed payment proposal and will instead retain the multiple levels of E/M codes with increased reimbursement. Therefore, CMS' current justification for including an add-on code (GPC1X) in the new E/M approach, no longer exists. However, CMS is still introducing this add-on code, even though the proposed system for which it was concocted has been abandoned. With this add-on code, the agency is in effect creating a

new coding scheme that inappropriately discriminates among physician specialties – favoring primary care, and further penalizing surgeons.

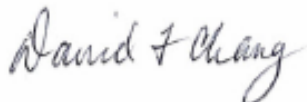
Compounding Effect of E/M Global Code Policy and Add-on Code

These two CMS proposed policies—to not apply a proportionate increase to the E/M component of global codes and moving forward with the unjustified add-on code—will in combination have a devastating effect on reimbursement for all surgical care, and eye surgery in particular. Due to the statutory requirements for budget neutrality under the Medicare Physician Fee Schedule, when additional Relative Value Units (RVUs) are added, such as the increase for stand-alone E/M services, as well as the add-on codes, a corresponding across-the-board reimbursement reduction becomes necessary in order to fund the increases.

Additional information on these issues is included in three attachments.

Again, I thank you for your time and consideration for this issue. If you need additional information, please contact Nancey McCann, ASCRS Director of Government Relations, at nmccann@ascrs.org or 703-591-2220.

Sincerely,



David F. Chang, MD
Member, ASCRS Executive Committee
Los Altos, CA

**CMS E/M Proposal Goes Against Precedent and Violates Current Law
(Attachment A)**

Background on Global Code Values

Medicare currently pays surgeons and other specialists a single fee (global payment) when they perform major or minor procedures such as back surgery, brain tumor removal, joint replacement, heart surgery, cataract surgery, colon resection, or provide maternity care. This single fee, which is established by CMS, covers the costs of the procedure plus related care before the procedure and follow-up care within a 10- or 90-day timeframe. For maternity care, this single fee covers nine months of prenatal care visits, labor and delivery and postpartum care. The services provided during pre-and post-operative/follow-up visits included in the global period are the same as the types of services that could be provided as stand-alone evaluation and management (E/M) visits.

In the CY 2020 Medicare Physician Fee Schedule (PFS) final rule published in November 2019, CMS increased the payment levels for stand-alone office and outpatient E/M codes. However, CMS did not apply the payment adjustment to the identical E/M portion of the global codes. Arbitrarily adjusting some E/Ms but not others conflicts with current law.

Rationale

If CMS applies the E/M adjustments to stand-alone office visit E/M codes, then such adjustments should also be made to the E/M component of the global codes, consistent with law as well as previous actions by the agency. It is imperative that CMS take this crucial step because the current policy:

- *Creates specialty differentials.* As part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239), which created the resource-based relative value scale (RBRVS) used to determine physician payment amounts, Congress specifically prohibits CMS from paying physicians differently for the same work in Medicare. This prohibition states that the "Secretary may not vary the . . . number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician." Failing to adjust the global codes does *exactly* this; - paying some physicians less for providing the same E/M services.
- *Relies on a faulty interpretation of section 523(a) of MACRA.* Through the Medicare Access and CHIP Reauthorization Act (MACRA), Congress required CMS to collect data on global codes. CMS' rationale for not adjusting the global codes relies on this ongoing data collection. Notwithstanding this ongoing project, nothing in Section 523(a) of MACRA precludes CMS from adjusting the global codes. In fact, the rule of construction specifically authorizes CMS to do so.

**CMS Proposal to Create Add-on Code Is No Longer Justified
(Attachment B)**

Background on CMS Add-on Code

The code sets to bill for E/M services are organized into five levels. In general, the more complex the visit, the higher the level of code a physician or provider may bill, and the higher E/M visits to reduce documentation burden by providing a single payment rate for E/M level 2-5 visits at approximately a level 3 payment rate. Because specialties that typically bill levels 4 and 5 E/Ms would experience payment cuts, CMS created add-on codes to provide an additional payment specifically for primary care and certain specialty visits.

However, CMS did not move forward with the single payment proposal and will instead retain the multiple levels of office and outpatient E/M codes. According to CMS, despite finalizing increased payment for office and outpatient E/M codes (some levels with payment increases above 40%), CMS desires to pay even more for certain types of services without expressing what additional resources those services or visits require. In the proposed rule estimates, the agency expects the newly proposed add-on code, GPC1X, to be used to provide additional payment for 100 percent of claims provided by certain specialties. However, CMS' original justification for the creation of this add-on code no longer exists and is now unnecessary.

Rationale

- *Creates distortion rather than correcting it.* The add-on code was initially proposed last year to compensate specialties who billed predominately level 4 or 5 E/Ms. These physicians would have been disadvantaged by the lower payment rate resulting from the prior CMS proposal to create a single payment rate for E/M levels 2-5. This year, CMS opted instead to keep the 5 levels of codes. Therefore, instead of correcting payment distortions caused by the CMS E/M policy proposal, the implementation of this code would create its own distortion, benefiting some while disadvantaging others without justification.
- *No longer needed.* If more time or work is required for visits provided by these specialties, they may simply bill a higher-level E/M code to account for the extra time or work. CMS has not explained what additional resources these specialties use for which payment is not covered under the existing revised E/M codes, thereby necessitating the additional payment from the add-on code.

Impact Chart
(Attachment C)

| Specialty | Current CMS Policy | Apply E/M Adjustment to Global Code & Eliminate Add-on Code |
|------------------------------------|---------------------------------|---|
| | Projected 2021 Medicare Payment | Projected 2021 Medicare Payment |
| Cardiac Surgery | -7.01% | -3.49% |
| Thoracic Surgery | -6.76% | -3.10% |
| Ophthalmology | -6.57% | 1.26% |
| Vascular Surgery | -6.43% | -3.27% |
| Neurosurgery | -6.05% | -1.76% |
| Plastic and Reconstructive Surgery | -6.04% | 1.05% |
| General Surgery | -5.67% | -1.14% |
| Colon Rectal Surgery | -5.43% | -1.17% |
| Surgical Oncology | -4.63% | 0.79% |
| Maxillofacial Surgery | -4.43% | 1.92% |
| Orthopaedic Surgery | -3.88% | 1.11% |
| Hand Surgery | -3.80% | 3.11% |
| Anesthesiology | -2.91% | -0.22% |

The Society of Thoracic Surgeons

Medicare Physician Fee Schedule (MPFS) 2016

“In general, STS agrees with comments provided separately by the ACS, specifically as they pertain to practice expense, PLI RVUs and overall accuracy of the global package:

- **Practice expense:** As CMS values the procedure itself, separate from the global code, the agency should incorporate the PE value that is unique to follow up visits in the base or “parent” code. This will prevent an unfair devaluation of the cost of supplies, labor, and equipment that is consumed in caring for the Medicare patient in the post-operative outpatient visits. In addition, there are a number of post-operative services included in 10- and 90-day global codes that cannot be reimbursed using the current separately billable E/M codes. These post-operative services represent real dollar cost outlays by surgeons, both for supplies as well as labor, that are fairly paid for using the existing methodology in the 10- and 90- day global codes, but would be unpaid if surgeons were left to bill for them by using E/M codes. Examples of these services are listed in the Medicare Claims Processing Manual and include items such as: dressing changes; local incision care; removal of operative packing; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters; routine peripheral intravenous lines; nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.
- **Professional Liability Insurance:** In valuing the individual components of a global service separately, it is important that CMS prevent potential artificial reductions in PLI RVUs for some specialties. We urge CMS not to use a methodology that redistributes the PLI associated with the global period to other specialties. A revised PLI formula should also properly and fairly credit resource-based specialty PLI costs to each specialty proportional to its own unique PLI costs.
- **Overall Accuracy:** CMS is also interested in stakeholder input regarding the overall accuracy of the values and descriptions of the component services within the global packages. With respect to the application of multiple procedure payment reduction policy, we agree with the ACS comment that, continuing to apply the same reduction percentage to the procedure component of the 10- and 90-day global code alone would inappropriately reduce the payment for second and subsequent surgical services.

To collect auditable, objective data that identifies the number and type of visits and other services furnished by the practitioner reporting the procedure code during the current postoperative periods, STS recommends that CMS consider requesting that all physicians report the number of minutes spent for an E/M visit whether or not such services are provided in the postoperative period. For services that occur within the postoperative period, providers could report 99024 with the minutes spent for the visit. This would provide CMS with objective data that would be suitable for audit without adding much complexity for physicians reporting services. By collecting the amount of time spent on all E/M services, CMS would be able to compare the postoperative visit time to an E/M service provided outside of the global period. This would allow analysts to determine if similar time is being spent for stand-alone E/M services and postoperative E/M services and if the visits differ. CMS could use the time criteria established for the E/M visits to determine the level of postoperative services provided for the postoperative E/M services during the global period.

We encourage CMS to develop a non-payment code similar to 99024 to facilitate the collection

of information for other items and services relating to the surgery that are provided during the global period. This unique code could identify services that are furnished but not separately billable after the day of the procedure during the global period. Practitioners would report either the time spent providing the service or reference an existing CPT code if one is available. This “new 99024” code should not be reported for E/M services or services that can be billed with a modifier during the global period. In addition, it should only apply to those additional services or interventions that occur after the day of surgery that cannot otherwise be billed such as removal of a chest tube following aortic valve replacement surgery or removal of an Intra Aortic Balloon Pump for any number of cardiac surgical procedures.

As CMS is aware, it is costly to develop and collect tools for data acquisition. Therefore, we encourage CMS to consider developing new ways of providing additional compensation for data collection. Further, we firmly believe that collection and analysis of these data should be an integral component of the valuation process. STS has a RUC-approved methodology that has been accepted by CMS to value the individual components of the global surgical package. STS methodology utilizes time and intensity data to value the procedure itself (including the pre- and post- time), ventilator duration, ICU length of stay (LOS), and overall hospital length of stay data, as well as an expert panel to determine the number and level of hospital visits for a procedure. In addition, an expert panel is used to determine the number of office visits required for a procedure. STS utilized data from the STS Adult Cardiac Surgery Database to determine, intraservice time, ventilator time, ICU and hospital LOS time.

To determine an appropriate value for the procedure itself, procedure time and procedure intensity are of paramount importance. STS suggests that CMS work with the RUC to determine an accepted intensity survey process and formulaic scale that can be utilized across specialties to accurately determine the intensity for the procedure. Once this intensity measure is established, the surveyed intensity (or intensity scale), the surveyed or database intra-service time, and the pre and post procedure time packages from the RUC can be used to value the procedure itself to ensure that it is properly valued within the global package.”

MPFS 2017

“Congress was united in opposition to the policy in the CY 2015 PFS final rule that would have transitioned all 10- and 90-day global codes to 0-day global codes beginning in 2017, because of concerns that the change would compromise patient care and significantly increase administrative burdens. Instead, Congress required CMS to collect data, starting January 1, 2017, on the number and level of visits furnished during the global period. Specifically, Section 523 of MACRA explicitly calls for CMS to gather information needed to value surgical services from a “representative sample” of physicians. Beginning in 2019, CMS must use these data to facilitate accurate valuation of surgical services.

We appreciate that CMS is not proposing at this time to implement the 5% withhold for services on which the practitioner is required to report, and we encourage CMS to maintain its proposal to avoid implementing the 5% withhold in the final rule. However, the CY 2017 PFS proposed rule disregards congressional mandate and requires any practitioners who furnish a procedure that is a 10- or 90-day global code report the pre- and post- operative services furnished on a claim using proposed “G-codes.” The proposal will impose an undue administrative burden on the surgical community, disproportionately directing provider resources toward compliance and away from patient care. This burden will likely be compounded by other new reporting requirements from MACRA

implementation, which is the most significant physician payment change in 25 years. Taken as a whole this has the potential to negatively impact both quality and access for patients.

We ask that CMS not implement this proposal in the final rule but instead include policy that reflects the law as passed to collect data from a “representative sample” that is the least-burdensome, yet adequate sample to yield statically viable results.”

MPFS 2018

“STS continues to have strenuous concerns with the methodology employed by CMS to collect data on global surgical payments. We have very little faith that mandatory reporting of a single code (99024) for every postoperative visit performed by surgeons in nine states and a broader survey of surgeons across the United States will provide CMS with valid and actionable information. We also fear surgeons were not adequately educated and prepared for the mandatory submission of 99024 codes for postoperative visits. Without the time needed to effectively educate providers on the data collection and without CMS’s communication regarding logistics, submission, and analysis of the data, we fear that CMS will not accurately capture the data needed for a comprehensive view of postoperative care. Without an accurate picture of postoperative care, the potential re-valuation of global surgical services may be seriously flawed.

We ask that CMS halt implementation of data collection until the data collection methodology can be validated. Further, we encourage CMS to provide more education to providers on this data collection effort to ensure a more complete picture of the postoperative services of cardiothoracic surgeons.”

MPFS 2019

“As required by the Medicare Access and CHIP Reauthorization Act (MACRA), CMS implemented a process for collecting data on the number and level of post-op visits related to 10- and 90-day global codes. CMS provided several reporting statistics in the proposed rule from states where reporting was required. Of the clinicians who were required to report CPT code 99024 for post-operative visits based on the policy effective July 1, 2017, only 45 percent reported one or more visits during the first six-month period ending December 31, 2017. Among 10-day global procedures performed in that window, only 4 percent had one or more matched visits reported with CPT code 99024. CMS indicated that it is possible that clinicians are not consistently reporting post-operative visits but did not rule out the possibility that post-operative visits are not being provided if not reported, especially in the case of 10-day global procedures.

STS joined the American College of Surgeons (ACS) and a number of other surgical specialty societies to inform our members of the global codes data collection reporting requirements leading up to July 1, 2017 and afterwards. Despite our best efforts, however, it is highly unlikely that all clinicians who are required to report are doing so for every post-operative visit for every procedure. Anything short of perfect reporting will result in inaccurate data that should not be used to revalue global codes. We believe that

CMS has met the MACRA requirements to collect data on the number of post-operative visits. CMS has indicated that it will soon be surveying three additional codes for data related to the level of visits—we believe this will satisfy the data collection portion of the law. MACRA also requires that CMS “improve the accuracy” of global codes based on the data that are collected or other available data.

STS does not believe that the data that have been collected can be used to improve the accuracy of the existing codes, and we urge CMS not to proceed with revaluing global codes at this time.”

MPFS 2020

“CMS states that it is interested in “exploring new options for establishing PFS payment rates or adjustments for services that are furnished together” and cites several examples of bundled payment models that are being tested by the Center for Medicare and Medicaid Innovation (the Innovation Center). CMS seeks comment on “opportunities to expand the concept of bundling to recognize efficiencies among physicians’ services paid under the PFS and better align Medicare payment policies” to improve individual health care, improve the health care of communities, and lower costs.

Bundled payment policy is predicated on the notion that bundles will facilitate care coordination and better coordinated care will improve quality and reduce cost. Alternative payment models should change how we pay for care in addition to changing what is being paid for. We are grateful that CMS, through the Innovation Center, has sought to collaborate with cardiothoracic surgeons in implementing the next phase of the Bundled-Payment for Care Improvement – Advanced (BPCI-A) initiative. However, we are afraid the success of this experiment may be muted by implementation issues, and not due to the nature of the collaboration. Other CMS bundled payment efforts in cardiothoracic have failed, not because cardiothoracic surgeons are unwilling to try new payment models, but because CMS had proposed to use quality measures that were essentially meaningless. For example, the proposed CABG Episode Payment Model, which was never implemented, was intended to use all-cause mortality, and little else, to measure quality. CABG mortality is already very low – approximately 2 percent. Attempting to distinguish performance differences using this measure alone would be statistically challenging and would yield few high or low performing outliers. Importantly, the 11 individual measures in the STS CABG Composite and the overall composite measure methodology are all endorsed by the National Quality Forum (NQF) and have undergone careful scrutiny by quality measure experts. We are grateful that the BPCI-A program is looking to incorporate this more meaningful measure, among others.

The STS National Database was established in 1989 as an initiative for quality assessment, improvement, and patient safety among cardiothoracic surgeons. The Database has three components—Adult Cardiac, General Thoracic, and Congenital Heart. The fundamental principle underlying the STS National Database initiative has been that surgeon engagement in the process of collecting information on every case, combined with robust risk adjustment based on pooled national data, and feedback of the risk-adjusted data provided to the individual practice and the institution, will provide the most powerful mechanism to change and improve the practice of cardiothoracic for the benefit of patients. We firmly believe that if we are able to create a clinical/financial tool by combining the STS National Database with claims data, we can help hospitals and surgeons to improve quality and generate savings in the hospital setting. Further, providing that level of support will also assist the system in reducing post-acute care costs by ensuring that providers have the ability to identify best practices that can help keep patients from requiring care at a Skilled Nursing Facility or Inpatient Rehabilitation Facility to begin with.

The STS National Database has facilitated advancements in many aspects of health care policy, including public reporting of health care quality measures, medical technology approval and coverage decisions, and even saving money by helping cardiothoracic surgeons to find more efficient and effective ways to treat patients. We have regional examples of combining STS National Database data with claims information, such as the Virginia Cardiac Services Quality Initiative (VCSQI).

VCSQI is an example of how a model, based on the current 90-day global payment period, has already been operationalized. In existence since 1993, the VCSQI currently has amassed a database by combining the STS National Cardiac Database for Virginia with the patient's UB-04 financial record for over 100,000 patients undergoing cardiac surgery in that region. That database therefore combines the patient's clinical outcome with his/her financial cost record for over 98 percent of all patients undergoing cardiac surgery in Virginia. Evidence-based protocols for treatment of post-operative atrial fibrillation, transfusion reduction in cardiac, early extubation following open heart surgical procedures, and glucose management have saved approximately \$90 million dollars in reduction of post-operative mortality and morbidity in cardiac surgery. Such an organization and ability to track and measure outcomes would be readily able to pilot models of alternative payment methodology. Future iterations of this tool could also be linked with other sources of clinical data like the American College of Cardiology's National Cardiovascular Data Registry (NCDR®) to facilitate a longitudinal, population management payment model.

If the agency's objective is to create value in health care, indeed, the most valuable tool for patients who are interested in making proactive choices about their health care is value transparency. Fortunately, the STS Database already provides for quality transparency through STS Public Reporting online. If CMS were to adequately implement Section 105(b) of MACRA (Pub. L. 114-10), we would have access to Medicare claims data, or the cost denominator of the value equation.

Finally, it is worth pointing out that CMS has considerable experience with bundled payment in the form of global surgical payments. Yet while CMS touts the advantaged of bundled payment to facilitate better care coordination, it simultaneously seems intent on dismantling global surgical payments. The policy argument supporting bundled payments is that care provided under bundled payment is greater than the sum of its parts. CMS should remember this when it considers the value of the surgical global.”

MPFS 2021

“CMS proposes to make changes in the work RVUs for services other than the global surgical codes for which the values are closely tied to the values of the office/outpatient E/M visit codes, as many services have E/M visits “explicitly built into their definition or valuation.” Services that CMS is proposing to revalue since they are analogous to the office and outpatient E/Ms include the following: End-Stage Renal Disease (ESRD) Monthly Capitation Payment Services, Transitional Care Management (TCM) Services (99495, 99496), Maternity Care Services, Assessment and Care Planning for Patients with Cognitive Impairment, Initial Preventive Physical Examination (IPPE) and Initial and Subsequent Annual Wellness Visits (AWV), Emergency Department Visits, Therapy Evaluations and Behavioral Healthcare Services.

At the same time, CMS is not proposing increases to the ophthalmological services that were requested for review based on the premise that they have not been reviewed by the RUC since 2007 and they are “not sufficiently analogous or connected to the office/outpatient E/M visits” even though they have historically been valued related to those services. CMS is also not recommending that the office/outpatient E/M visit increases be passed through to the 10- and 90-day global services as they have been in the past and recommended by the AMA/Specialty Society RVS Update Committee (RUC). CMS states that they did not “make changes to the valuation of the 10- and 90-day global surgical packages to reflect changes made to values for the office/outpatient E/M visit codes while they continue to collect and analyze data on the number and level of office/outpatient E/M visits that are actually being performed as a part of these services.”

STS strongly disagrees with CMS' proposal to revalue services analogous to office and outpatient E/M visits without formal review of those codes. It is inconsistent of CMS to consider increasing values that are closely tied to the values of the office/outpatient E/M visit codes and/or codes that have E/M visits "explicitly built into their definition or valuation" for some services and not others. CMS' proposal to increase the values for the End-Stage Renal Disease (ESRD) Monthly Capitation Payment Services, Transitional Care Management (TCM) Services, Maternity Care Services, Assessment and Care Planning for Patients with Cognitive Impairment, Initial Preventive Physical Examination (IPPE) and Initial and Subsequent Annual Wellness Visits (AWV), Emergency Department Visits, Therapy Evaluations and Behavioral Healthcare Services but not the Ophthalmological Services or the E/M visits included in the global surgical package is incongruous. It is especially concerning since there are office/outpatient E/M visits that are actually included in the global surgical package, so the relationship to the changes is absolute. As with other potentially misvalued services (over or under paid), the codes identified by CMS that do not have the office/outpatient E/M codes built in as an independent variable of the code should be subject to the same process for other potentially misvalued services. The services that CMS has identified as analogous to the office/outpatient E/M visit codes should be submitted as potentially misvalued services and subject to review by the RUC and surveys to determine if in fact an increase is warranted. Many of the identified codes haven't been reviewed for several years and there is no evidence that the work has increased comparable to the E/M office/outpatient visit codes. CMS should obtain data to support any changes in the work or practice expense related to any service, including those that are considered analogous to the office/outpatient E/M codes.

Conversely, the global surgical service values have been provided to CMS with the recommendation of the AMA RUC. The global surgical codes are designed to include both in-hospital and outpatient E/M visits. The revised E/M codes are specific to office/outpatient visits, yet CMS has universally declined to apply recommended work and time incremental increases for this aspect of care provided in the post-operative period, which is inconsistent with their past actions. We reiterate that it is inappropriate for CMS to not apply the RUC-recommended changes to global codes starting in CY 2021. To do otherwise will:

- Disrupt the relativity in the fee schedule: CMS is effectively and arbitrarily changing the values for some E/M office visit services, but not others, disrupting the relativity between codes across the Medicare physician fee schedule. This relativity was mandated by Congress, established in 1992, and has been refined over the past 27 years. Historically, CMS itself has ensured this relativity between office/outpatient E/Ms by increasing the value to global services because of the direct relationship between the codes in the significant revaluations of office/outpatient E/Ms in 1997, 2003, and 2011.
- Create specialty differentials: Per the Medicare statute, the "Secretary may not vary the...number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician."⁴ Failing to adjust the global codes is tantamount to paying some doctors less for providing the same E/M services, in violation of the law.
- Ignore recommendations endorsed by nearly all medical specialties: The RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full increase of work and physician time for office visits be incorporated into the post-operative visits of the global surgery codes for each CPT code with a global of 10- day, 90-day and MMM (maternity). The RUC also recommends that the practice expense inputs should be modified for the office visits within the global periods

- Inappropriately rely on section 523(a) of MACRA: In the CY 2021 PFS proposed rule, CMS refers to its decision in the CY 2020 PFS final rule to not make changes to the valuation of the 10-and 90-day global surgical packages to reflect the increased values for the office/outpatient E/M visit codes while the agency continues to collect data on the number and level of post-operative visits included in global codes as required by MACRA. The MACRA data collection requirement, set forth in section 523(a), does not prohibit CMS from applying the RUC-recommended incremental increases to the office/outpatient E/Ms codes to global codes. In fact, section 523(a) specifically authorizes CMS to adjust surgical services, notwithstanding the mandate to concomitantly undertake the MACRA-mandated global code data collection project. In addition, it is inappropriate for CMS to rely on the implementation of MACRA, which passed in 2015, as a reason to refrain from making necessary updates in 2021. This inaction unfairly punishes a subset of physicians who additionally, like all healthcare practitioners, are experiencing the pressures of a global pandemic.

CMS' failure to incorporate RUC-recommended work and time incremental increases for the revised office/outpatient visit E/M codes in the global codes is unacceptable, particularly in light of the adjustments proposed for other bundled services, such as the maternity codes. Increasing the visits bundled into the surgical global payment would increase spending by approximately \$440 million, requiring an approximate 0.4% reduction to the Medicare conversion factor. This is a minor budget neutrality impact in comparison to the impacts proposed for the increases to the stand-alone office visits and other CMS proposals. Organized medicine has been united in its recommendations that CMS incorporate the incremental revised office/outpatient E/M values in the global codes, as evidenced by the many comment letters and meetings over the past year. We are, therefore, deeply disappointed that CMS continues to ignore these recommendations in the CY 2021 Medicare PFS proposed rule.

As an example of the drastic cuts to reimbursement for cardiothoracic surgery over time, since 1987, reimbursement for a three vessel (one artery, two veins) coronary artery bypass graft (CABG) has dropped precipitously to less than one quarter of its original value (in relative terms). It is difficult to see how further changes to reimbursement would not negatively impact patients' access to care, especially as hospitals and health systems are struggling to account for huge economic losses.

In order to ensure practices facing severe economic strain and uncertainty are able to continue meeting the needs of patients during and after the pandemic, STS strongly urges CMS/HHS to use its authorities and flexibilities under the Public Health Emergency (PHE) to implement the office visit increases and waive the requirement for CMS to adjust Medicare physician payments for budget neutrality when it implements the office visit coding and payment changes that it has finalized for 2021. We also urge CMS to apply the RUC recommended changes to the office/outpatient E/M component of the global codes to maintain the relativity of the fee schedule.”

MPFS 2022

“It is inappropriate for CMS to apply the RUC-recommended changes to stand-alone, in-office E/M visits but not for E/M services that are imbedded within global surgical codes. CMS' persistence in this policy for yet another year:

- Disrupts the relativity in the fee schedule: CMS is arbitrarily changing the values for some E/M office visit services, but not others, disrupting the relativity between codes across the Medicare physician fee schedule. This relativity was mandated by Congress, established in 1992, and has been refined over the past 27 years. Historically (1997, 2003 and 2011), CMS itself has ensured this relativity between office/outpatient E/Ms and those associated with global surgical codes

by increasing the value to global services commensurate with, and identical to, increases in office / outpatient E/M because of the direct relationship between the codes in the significant revaluations of office/outpatient E/Ms.

- Creates specialty differentials: Per the Medicare statute, the “Secretary may not vary the...number of relative value units for a physicians’ service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.”¹ Failing to adjust the global codes is tantamount to paying some doctors less for providing the same E/M services, in violation of the law. CMS’s ongoing non-compliance with the law is disturbing, and we ask by whose authority are they able to remain non-compliant for yet another year.
- Ignores recommendations endorsed by nearly all medical specialties: The RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full increase of work and physician time for office visits be incorporated into the post-operative visits of the global surgery codes for each CPT code with a global period of 10-day, 90-day and maternity codes. The RUC also recommends that the practice expense inputs should be modified for the office visits within the global periods.
- Inappropriately relies on section 523(a) of MACRA: In the CY 2021 PFS proposed rule, CMS refers to its decision in the CY 2020 PFS final rule to not make changes to the valuation of the 10- and 90-day global surgical packages to reflect the increased values for the office/outpatient E/M visit codes while the agency continues to collect data on the number and level of post-operative visits included in global codes as required by MACRA. The MACRA data collection requirement, set forth in section 523(a), does not prohibit CMS from applying the RUC-recommended incremental increases to the office/outpatient E/M codes to global codes. In fact, section 523(a) specifically authorizes CMS to adjust surgical services, notwithstanding the mandate to concomitantly undertake the MACRA-mandated global code data collection project. In addition, it is inappropriate for CMS to rely on the implementation of MACRA, which passed in 2015, as a reason to refrain from making necessary updates. CMS continues to make and/or defer policy decisions, such as their proposal to bundle critical care visits with procedure codes that have a global surgical package in Section II (F)(2)(g) of this proposed rule, under the premise of continued assessment of values for global surgery procedures including the number and level of pre and postoperative visits. CMS is arbitrarily making or deferring changes to code valuations and policy in a manner that suits their needs as opposed to applying the guidance in a consistent manner.

The agency’s flawed decision to use the MACRA statute to continue to stall in implementing a change to global reimbursement, unfairly punishes a subset of physicians. CMS’ failure to incorporate RUC-recommended work and time incremental increases for the revised office/outpatient visit E/M codes in the global codes is unacceptable, particularly considering the adjustments proposed for other bundled services, such as the maternity codes. CMS further penalizes surgeons in the *Proposed Valuation of Specific Codes for CY 2022* section (II)(E)(4) of this rule for procedures where the global periods are changing from 90-day or 10-day global periods to 0-day global periods. One example appears to occur where CMS utilizes a reverse building block methodology (BBM) using the new 2021 E/M values and time to determine a work RVU even though the 2021 increases were not included in the E/M codes that are included in the global surgical package; furthermore, the codes were valued using magnitude estimation. Using a reverse building block methodology (BBM) with 2021 E/M office visit code values on codes that were valued using magnitude estimation is inappropriate resulting in additional unsubstantiated decreases in surgical procedure work valuations. CMS could easily address this

disparity by increasing the visits bundled into the surgical global payment which would increase spending by approximately \$440 million, requiring an approximate 0.4% reduction to the Medicare conversion factor. This is a minor budget neutrality impact in comparison to the impacts proposed for the increases to the stand-alone office visits and other CMS proposals. Organized medicine has been united in its recommendations that CMS incorporate the incremental revised office/outpatient E/M values in the global codes, as evidenced by the many comment letters and meetings over the past year.”

Survey on Global Surgery Data and Reporting Requirements

Report on Medicare's New Coding Proposal and the Impact on Surgeons and their Practices



Prepared by the
Surgical Coalition

August 2016

Medicare's Global Surgery Payment Policy

Background

Under the current system, Medicare pays surgeons and other specialists a single fee when they perform complex procedures such as back surgery, brain tumor removal, joint replacement, heart surgery, or colon resection. This single fee covers the costs of the surgery plus all follow-up care within a 10- or 90-day timeframe. The surgeon gets one payment, and the Medicare beneficiary only pays a single co-pay. In the CY 2015 Medicare Physician Fee Schedule (PFS) final rule, the Centers for Medicare & Medicaid Services (CMS) included a policy that would have eliminated global surgical payments, which would have negatively affected patients and physicians alike.

Recognizing the significant problems associated with this proposal, Congress was united in opposing this global surgery code policy because of concerns that the change would compromise patient care and significantly increase administrative burdens. Instead, Congress required CMS to collect data, starting January 1, 2017, on the number and level of visits furnished during the global period. Specifically, Section 523 of the Medicare Access and CHIP Reauthorization Act (MACRA) explicitly calls for CMS to gather information needed to value surgical services from a "representative sample" of physicians. Beginning in 2019, CMS must use these data to facilitate accurate valuation of surgical services.

Medicare's Burdensome Data Collection Plan

Despite this Congressional mandate, on July 15, 2016, in the proposed rule for the CY 2017 Medicare PFS, CMS announced a unilateral decision to implement a new sweeping mandate to collect data about global surgery services. According to the proposal, beginning on January 1, 2017, **all** surgeons — instead of a representative sample — providing 10- and 90-day global surgery services to Medicare patients will be required to use an **entirely new set of G-codes** to document the type, level and number of pre- and post-operative visits furnished during the global period for **every** global surgery procedure provided to Medicare beneficiaries. Under this system, surgeons would be required to use a these G-codes to report on each 10-minute increment of services provided.

| | | |
|----------------------------|-------|---|
| Inpatient | GXXX1 | Inpatient visit, typical, per 10 minutes, included in surgical package |
| | GXXX2 | Inpatient visit, complex, per 10 minutes, included in surgical package |
| | GXXX3 | Inpatient visit, critical illness, per 10 minutes, included in surgical package |
| Office or Other Outpatient | GXXX4 | Office or other outpatient visit, clinical staff, per 10 minutes, included in surgical package |
| | GXXX5 | Office or other outpatient visit, typical, per 10 minutes, included in surgical package |
| | GXXX6 | Office or other outpatient visit, complex per 10 minutes, included in surgical package |
| Via Phone or Internet | GXXX7 | Patient interactions via electronic means by physicians/NPP, per 10 minutes, included in surgical package |
| | GXXX8 | Patient interactions via electronic means by clinical staff, per 10 minutes, included in surgical package |

Surgeons Must Make Major Practice Changes

In an effort to demonstrate to CMS the enormity of this task and its impact on patient care delivery, the surgical community conducted a survey to collect information to determine the feasibility of this unfunded data collection effort.

According to the survey's findings, surgeons will face significant challenges integrating the proposed new G-codes and data collection processes into their practices. In an attempt to comply, most physicians will have to make major changes to their practice operations. Some examples include:

- ◆ Developing new methods for tracking and collecting global surgery visit work;
- ◆ Making modifications to their EHR and billing systems;
- ◆ Incurring additional staff and physician time spent on tracking and processing global surgery information into EHR and billing systems;
- ◆ Developing methods for transferring visit data from one treatment site to another;
- ◆ Hiring scribes to shadow clinicians to document services;
- ◆ Using additional technology, such as handheld devices or stopwatches, to document time spent providing global surgery services; and
- ◆ Differentiating Medicare from other patients to ensure that G-codes are used based on the patient's payer.

Additionally, just under one-half of respondents anticipate that they would have to hire new staff and purchase additional software to capture global surgery services under a new G-code system.

| Major Changes to Surgeons' Practice Operations Required | |
|--|-------|
| Implementing a way to differentiate Medicare patients in the pre- and post-operative settings so G-codes are properly applied based on the patient's payer and data aggregated for this subset of patients in the practice | 89.3% |
| Spending additional physician time on tracking pre- and post-operative visit information beyond that which is currently dedicated to documenting medical services | 88.8% |
| Modifying electronic health record (EHR) and/or billing systems | 85.9% |
| Developing new processes for tracking, collecting and distinguishing between pre- and post-operative visit information | 82.8% |
| Developing new pre- and post-operative visit tracking forms | 81.5% |
| Increasing the number of claims submitted as well as incurring significant new costs for the additional submission | 76.9% |
| Spending additional existing staff time to track and process pre- and post-operative visit information into the medical record and billing system | 75.7% |
| Developing patient engagement and/or pre- and post-operative visit tracking forms | 65.3% |
| Developing a method for transferring pre- and post-operative visit data from one treatment site to another | 59.9% |
| Hiring new staff members to track and process pre- and post-operative visit information into the medical record and billing system | 48.7% |
| Using handheld technology to document time spent providing pre- and post-operative services | 46.4% |
| Purchasing additional software to support and capture pre- and post-operative visits | 39.9% |
| Hiring scribes to shadow clinicians to document services | 34.6% |

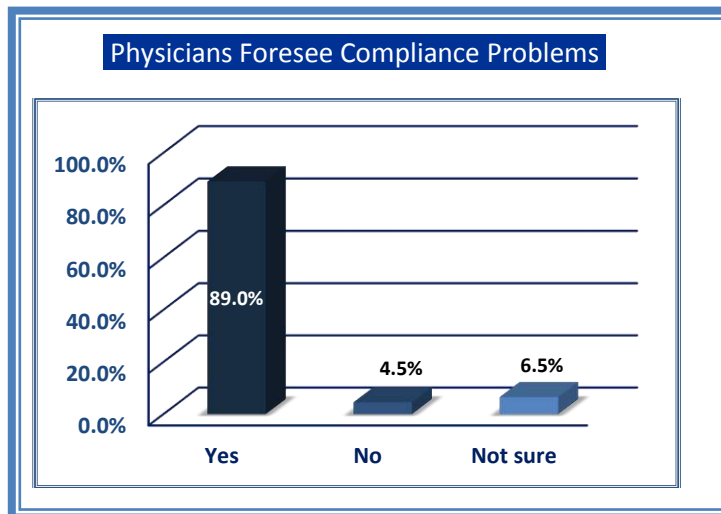
The study's results make it clear that this all-physician, all-services claims-based approach will be a costly and burdensome initiative that will likely yield incomplete and unreliable information.

A Costly Experiment

All of these practice changes will come at a significant cost to our surgeons. Nearly 40 percent of respondents anticipate it will cost them between \$25,000 to \$100,000, and another 15 percent estimate they will spend more than \$100,000 on compliance. These costs include modifications to EHR and billing systems, staff costs, loss of productivity and the like.

| | |
|-----------------------|-------|
| \$0 to 10,000 | 5.9% |
| \$10,001 to \$25,000 | 15.7% |
| \$25,001 to \$50,000 | 17.4% |
| \$50,001 to \$75,000 | 11.4% |
| \$75,001 to \$100,000 | 8.3% |
| Over \$100,000 | 14.9% |
| Not sure | 26.2% |

While CMS and its contractors may simply be able to “flip the switch” to incorporate the new G-codes into their claims processing systems, not surprising, nearly 90 percent of surgeons foresee physician compliance problems with the new global surgery G-codes.



In Surgeons' Own Words

A super majority of surgeons believe that using G-codes is not an appropriate method for collecting global surgery data. When asked for suggested alternatives to the G-code approach, a common theme emerged.

“Leave as is. It is a global period. Each patient receives as much care in the postoperative period as required. Starting to track with these G -codes will kill efficiency and further discourage my treating Medicare patients.”

Neurosurgeon employed by a hospital in a small, single specialty practice in the Midwest

“Why fix something that is not broken? Post-operative visits are so variable, I guess I just need to put myself on a clock and punch in and out when I leave the patients rooms or see them in my office. More administrative nightmares. How much more does CMS expect us to take?”

Orthopaedic surgeon in a small, single specialty private practice in the West

“As there is no separate reimbursement for the postop visit I would suggest that requiring documentation above and beyond current ‘need to know documentation’ will end up with less complete postop care as multiple appointments will seem onerous. As it is now, I like bringing postop patients back often as I know that it does not cost the patient.”

Otolaryngologist in a large multi-specialty, academic medical practice in the West

“Surveys are routinely performed for specific codes to determine this information. Thinking that mandating that a specific code to be used when billing will give more valid information is folly.”

Ophthalmologist in a small, single specialty practice in the Midwest

“Do not try to fix a system that's not broken!! Enough is enough already!”

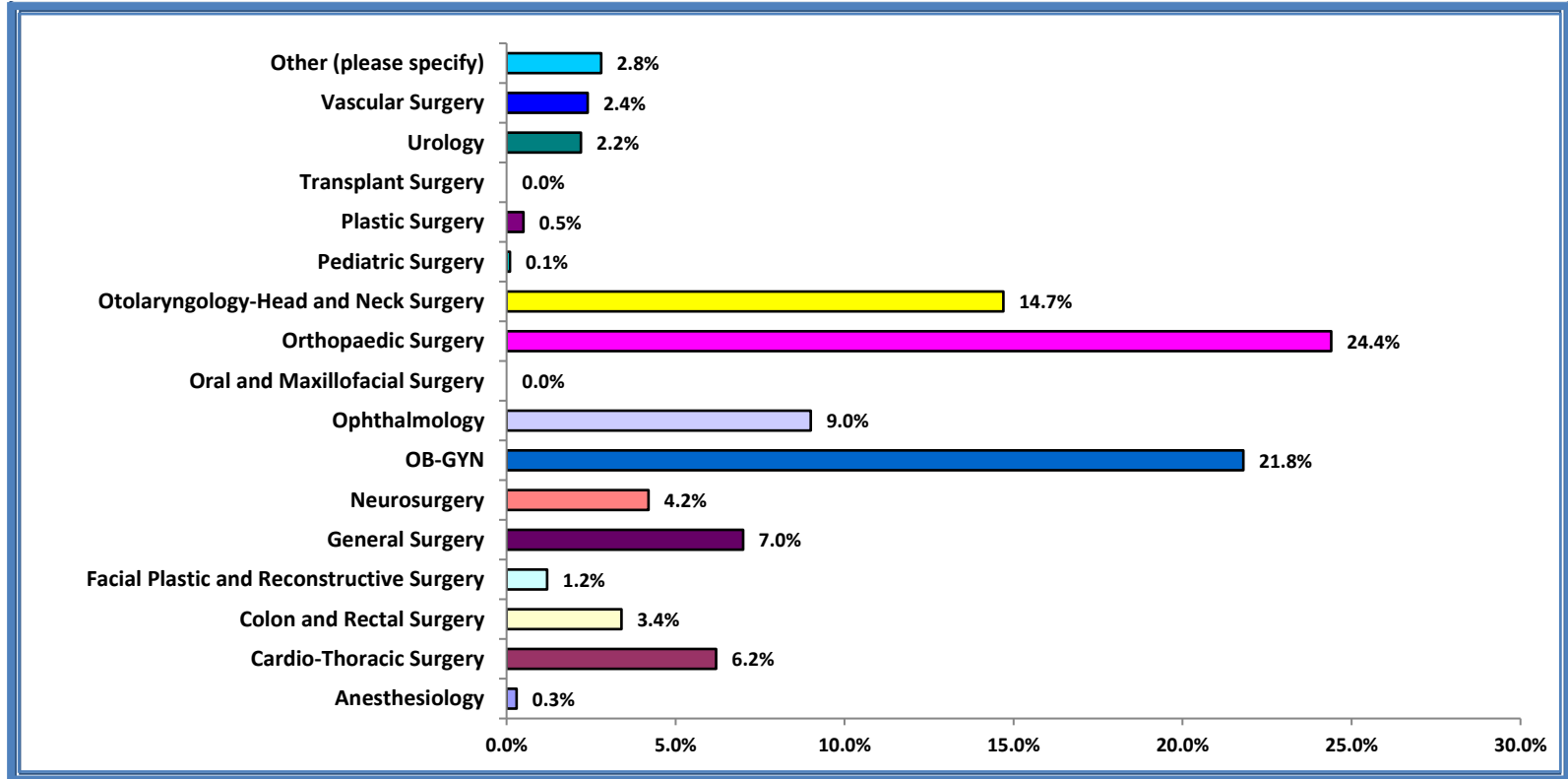
OB-GYN in a small, single specialty private practice in the Northeast

Survey Methodology

In July/August 2016 the Surgical Coalition conducted a survey of surgeons and anesthesiologists in an effort to determine the impact of CMS's proposal to use new G-codes to collect and report on the services provided during the 10- and 90-day global surgery period. The survey was conducted online. A total of 7,071 physicians participated in the survey.

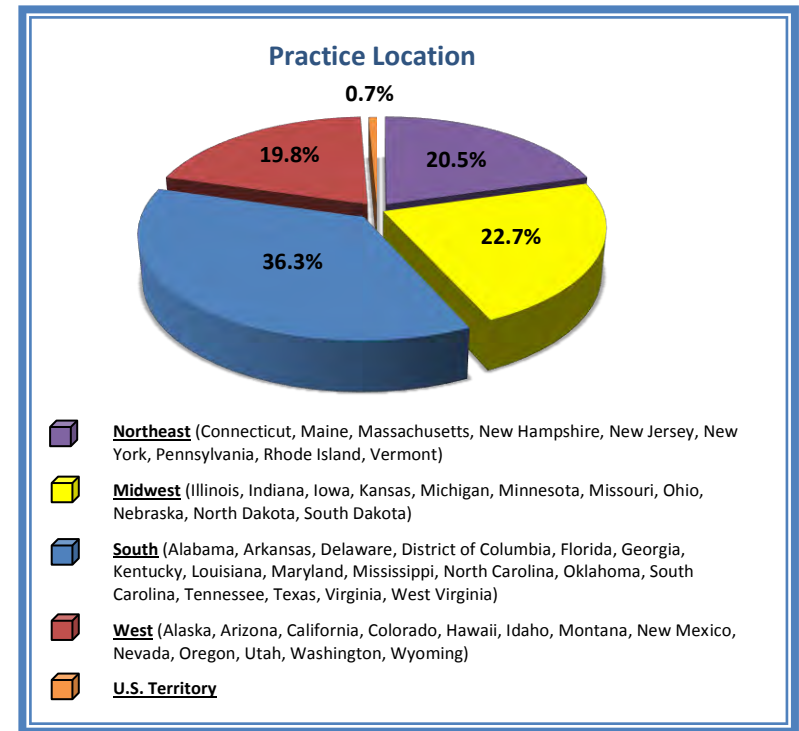
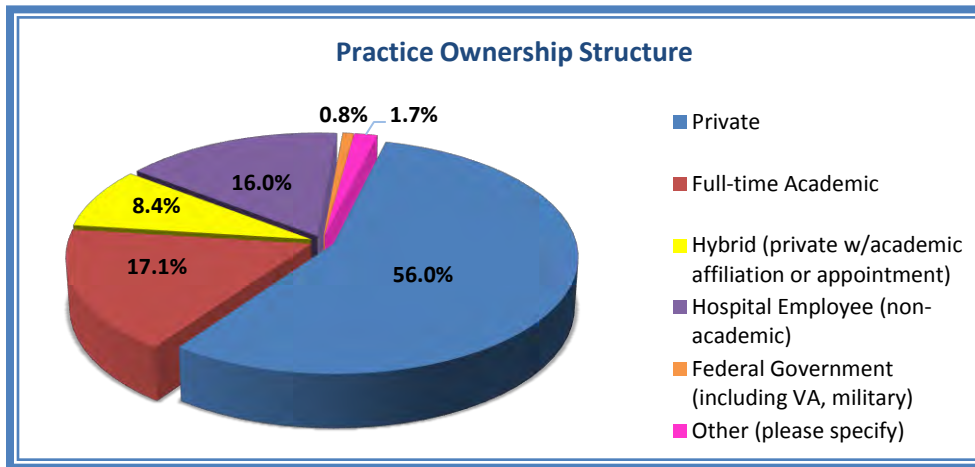
Demographics

Surgeons and other physicians from approximately 25 specialties completed the survey, including: Anesthesiology, Breast Surgery, Cardio-Thoracic Surgery, Colon-Rectal Surgery, Dermatology, Facial Plastic Surgery, General Surgery, GYN Oncology, Hand Surgery, Neurosurgery, OB-GYN, Ophthalmology, Oral Surgery, Orthopaedic Surgery, Otolaryngology, Pain Management, Pediatric Surgery, Plastic Surgery, Surgical Oncology, Transplant Surgery, Urology, Urogynecology, and Vascular Surgery.



Just over one-third of the respondents practice in the South, and the others are evenly distributed throughout the other regions of the country. Most surgeons practice in urban (38%) and suburban (43%) settings, with nearly fifteen percent practicing in rural parts of the country.

Over one-half of the respondents are in private practice, but all types of practices were represented, including private, academic, hybrid (private with academic affiliation or appointment) and hospital or other employment arrangement.



More than 40 percent of physicians responding are in solo or small, single specialty practices. It is, therefore, critical that CMS takes into account the additional administrative burdens this data collection effort will have on these physicians, in particular.

| PRACTICE SIZE | |
|--|-------|
| Solo | 16.0% |
| Small single specialty group (2-5 physicians) | 26.9% |
| Medium single specialty group (6-20 physicians) | 18.4% |
| Large single specialty group (more than 20 physicians) | 8.1% |
| Small multi-specialty group (2-5 physicians) | 1.7% |
| Medium multi-specialty group (6-20 physicians) | 4.5% |
| Large multi-specialty group (more than 20 physicians) | 23.5% |
| Other (please specify) | 0.9% |

Participating Organizations:

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Osteopathic Surgeons
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Osteopathic Academy of Orthopedics
American Pediatric Surgical Association
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society for Metabolic & Bariatric Surgery
American Society of Plastic Surgeons
American Urological Association
Congress of Neurological Surgeons
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Gynecologic Oncologists
Society of Surgical Oncology
The Society of Thoracic Surgeons

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