

March 3, 2015

Sean Cavanaugh  
Deputy Administrator & Director  
Center for Medicare  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

RE: Response to the Centers for Medicare and Medicaid Services (CMS) Concerning the Transition from Surgical Global Periods to 000-day Global Period

Dear Mr. Cavanaugh:

On January 31, 2015, the RUC, along with participating specialty societies and other stakeholders, held a robust 4 ½ hour discussion regarding the CMS decision to transition all 010- and 090-day surgical global codes to 000-day global periods by CPT 2018. The report from this RUC strategy session is appended to the letter, along with numerous data tables and analyses. These materials are being submitted to CMS and contain recommendations for CMS' consideration.

Since the creation of the Resource-Based Relative Value Scale (RBRVS), the AMA/Specialty Society RVS Update Committee (RUC) has remained committed to ensuring physician payment is accurate, fair and relative across the entire system. While the RUC and CMS are united in this goal, the RUC has substantial reservations regarding the CMS decision to transition all 010-day and 090-day surgical global codes to 000-day global periods by CPT 2018, which have previously been communicated to the Agency in public comments and face-to-face meetings. Additionally, the RUC contends that the timeline of the CMS transition, as described, is not feasible.

The RUC is seriously concerned that the newly enacted policy will not accurately account for physician work, practice expense and malpractice risk for services performed within the current surgical global period. **The RUC reiterates its previous position imploring CMS to rescind the newly adopted policy to transition away from 010-day and 090-day surgical global codes and to instead work in collaboration with the RUC to implement alternative mechanisms for addressing the concerns of the Agency.** Regardless of the CMS final decisions regarding how to proceed, we believe it is imperative that CMS continue to seek out the clinical expertise of the RUC as the Agency moves forward. CMS should not implement any transition away from 010-day and 090-day global services without first addressing the numerous methodological and process recommendations concerns, including practice expense, professional liability insurance costs and the multiple surgery payment reduction. This letter outlines several methodological and process recommendations for CMS to consider.

Prior to addressing each of CMS's explicit concerns with the current surgical global period construct, the RUC would like to convey several broad, consensus-based recommendations that were achieved during the strategic session.

**First, regardless of the merits of the arguments CMS sets forth to transition away from surgical global periods, the RUC unanimously agreed that the current transition timeline is unattainable in a fair and accurate manner.** CMS has stated that all 010-day global codes would be reviewed by CPT 2017 and all 090-day global codes would be reviewed by CPT 2018. Specialty societies will need time to properly survey these codes. It has been noted that the 010-day global codes will need to be revalued and accepted by CMS prior to the review of the 090-day global codes in order for these major surgical procedures to have anywhere near the number of comparator codes necessary to provide adequate magnitude estimation. The RUC recommends that the multi-specialty points of comparison (MPC) codes and their related family codes (as defined by the specialty) should be reviewed first to serve as initial anchors. Consideration will also need to be given to the paucity of 000-day reference services that are currently available for major surgical procedures.

Second, the RUC notes that the Agency's selected timeline implies that in order to actually review the over 4,200 surgical global codes in two years, a systematic, formula-based approach would need to be adopted so that numerous codes could be valued at once. However, there is no existing solution to systematically, accurately and efficiently transition surgical global codes to 000-day global codes. The work values associated with Evaluation and Management (E/M) services in a code's global period are not necessarily added to the service's work value to determine the final work RVU. These services are proxies representing a physician's typical case. Therefore, even if accurate claims data were available for post-operative E/M visits, simply using a reverse building block methodology to systematically convert all 010-day and 090-day global codes to 000-day global codes by backing out the bundled E/M services would be highly inappropriate. To support this conclusion, the RUC noted that if a reverse building block technique were applied to all 010-day and 090-day global services, nearly half of minor and major surgical procedures would be reduced to a work value reflecting a low intensity. **The RUC unanimously agreed that the reverse building block methodology, or any other purely formulaic approach, should not be used as the primary methodology to value surgical services.**

Third, the RUC stressed the need for CMS to consider the unintended consequences of its policy. Medicare beneficiaries will particularly be impacted by this proposal, as a co-payment will be required for each post-operative visit. This will undoubtedly have adverse consequences on outcomes when patients cannot return for needed care due to financial disincentives. In addition, the separate reporting of at least 62 million additional new claims to report not only the E/M services but also the additional miscellaneous post-operative services and supplies will add significant administrative burdens to an already over worked processing system. Furthermore, some private payors may choose to retain 010-day and 090-day surgical global packages, whereas many others would likely delay their transitions until several years after CMS made the change. Heterogeneous reporting mechanisms between payors would certainly result in additional administrative burden and confusion for all involved stakeholders, including patients.

Finally, an additional concern is the disruption of the secondary insurance market due to the uncertainty of the number and level of new E/M services that will result from this conversion.

In an effort to lay out the RUC's specific concerns in a concise manner, the below responses are constructed in such a way to specifically address each of the Agency's five key complaints against surgical global periods, as detailed in the 2015 Final Rule. In general the RUC believes that CMS should only move forward after obtaining the data we suggest so that any transition to zero day global services is informed by the best, most complete empirical data possible.

### **1. CMS Concern - Fundamental limitations in the appropriate valuation of the global packages with post-operative days**

CMS's initial argument against the bundled surgical global period is a broad criticism of bundled post-operative payment. CMS focuses on the need for accurate identification of the typical patient and scenario when valuing a service. Otherwise, payment disparities will be compounded as the average service performed on Medicare patients will differ from the initial assumption at the time of valuation. The RUC agrees with CMS that collecting accurate data on post-operative visits furnished by the practitioner reporting current 010-day and 090-day global codes is important.

While the RUC maintains that surveys obtained through the RUC process represent the most reliable, consistent, broadly applicable data currently available to CMS, this does not mean that the RUC survey is the only means by which to collect and verify accurate post-operative work. However, the RUC is disappointed that CMS chose to forgo a number of less intrusive data collection methods and instead adopted what is an entire restructuring of the Medicare payment schedule. This is why the RUC recommends that CMS collect and examine existing post-operative visit data in order to validate current surgical bundles and to facilitate informed decisions on how to proceed with current and future proposals.

There appear to be a number of other ways to address the Agency's concerns regarding payment accuracy. The following is a list of several alternatives discussed by the RUC:

- RUC review of outlier visits in codes – A screen of this nature has already been created identifying dozens of both 010-day and 090-day global period codes with outlier visits. Furthermore, only 9 percent of all 010-day global services have more than one post-operative visit and only 4 percent of all 090-day global services have more than five post-operative office visits.
- Data collection of CPT code 99024 – There are several large physician groups (e.g. Mayo Clinic and Geisinger) that already mandate the use of 99024 with all post-operative E/M services.
- Pilot test the transition of codes CMS considers of high concern.
- Use Medicare length of stay data to assess hospital visits.
- Required reporting of post-op visits via no-pay claims.

One potential method for data capture would be to collect and examine large group practice data for CPT code 99024 *Post-operative follow-up visit*, normally included in the surgical package, to indicate that an E/M service(s) was performed during a post-operative period for a reason(s)

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related to the original procedure. This service is currently status “B” (bundled) in Medicare physician payment schedule and is therefore not paid.

The RUC has identified several large hospital-based physician group practices that internally use CPT code 99024 to report each bundled post-operative visit, and therefore data is already being captured for many Medicare providers. Separately, the RUC also understands that CMS may have denied-claims data available for CPT code 99024 via the Medicare claims processing system.

At the January RUC meeting, CMS officials requested assistance from the RUC in gathering specific contact information from Medical Systems and other stakeholders that collect data on post-operative visits. Below are three such contacts; the RUC will continue to share new contacts with CMS as they are gathered.

**Contact information for extant data sources to potentially validate post-operative visits:**

*(First contact’s information redacted from public version of letter)*

*(Second contact’s information redacted from public version of letter)*

*(Third contact’s information redacted from public version of letter)*

Finally, it is currently possible for CMS to review Medicare Part A claims data to determine the length of stay of surgical services performed in the hospital facility setting. Matching the average length of stay with the post-operative visits in the physician time file would give CMS and other stakeholders the opportunity to identify anomalies within the data set that could be reviewed further.

**2. CMS Concern - Questions regarding accuracy of current assumptions**

In the 2015 Proposed and Final Rule, CMS expressed concern regarding the accuracy of current assumptions that are used to value surgical global services. The key concern provided was the perceived notion that the amount of post-operative visits bundled into surgical globals is

overstated. CMS continues to rely on three HHS Office of the Inspector General (OIG) Reports (ophthalmology, orthopaedic and cardiovascular services) to form the basis of their suspicion that the post-operative visits included in the surgical global periods are inaccurate. However, this premise relies on data that is now almost a decade old. Since publication, one-third of the codes identified in the reports have been reviewed by the RUC in the misvalued code project. Of those codes reviewed by the RUC, 46 percent received reduced post-operative visit recommendations. In addition, the RUC has already addressed the majority of the high volume codes in these reports. Of the codes that have not yet been reviewed since the release of the OIG reports, 74 percent have Medicare volume of less than 10,000.

As has been communicated numerous times, the OIG reports often relied on a review of records for only a handful of claims for an individual service. In contrast, the RUC requires a minimum survey sample size of 30 physicians, and the vast majority of the time receives more, to estimate the physician work in both the operative and post-operative periods. The RUC also collects data on the level of E/M visits, which the OIG report did not. These reports, while identifying an important area of concern for the RUC and CMS to focus on, are outdated and simply do not hold up to heavy scrutiny, especially when used as a major justification for radically reforming physician payment and beneficiary care in the United States.

Finally, apart from the specific issues with the OIG reports, the RUC is concerned that the Agency is looking for a level of precision that is neither obtainable nor necessary in a relative value scale. While the RUC exerts a great deal of effort and resources to gather accurate post-operative data, the most important element of valuation within the RBRVS is the relativity within similar services and across the spectrum of physician services. The concept of reviewing micro data sets to estimate post-operative visits in fractions is simply counterproductive. These tools are helpful in identifying specific issues, but not in creating universally adopted assumptions across thousands of unique services. This is why CMS must further study this issue with the tools listed above in order to understand the complete landscape of potential issues within surgical global periods.

### **3. CMS Concern - Limitations on Appropriate Future Valuations of 010- and 090-Day global codes**

Under this argument, CMS communicates concerns about the perceived ambiguity over the actual value of individual surgical services, as each work RVU represents a bundle of both the operative and post-operative physician work. CMS is also concerned that some surgical services were valued based on the building block methodology, while others were valued using magnitude estimation.

The RUC has worked under the prevailing assumption that magnitude estimation is the standard for valuation of all physician services, including those with global surgical packages. Thus, the work values associated with E/M services in a code's global period are not necessarily added to the physician work value to determine the final work RVU. These services are proxies representing a physician's typical case. The RUC then employs magnitude estimation based on survey data to assign the work RVU and reviews the data to determine the typical E/M services provided in the global period.

Although it seems reasonable to know the value of the procedure that is currently embedded in the value of the global period, it has never been the intention of the RUC or CMS to make this determination. In summary, to do so fairly and accurately with appropriate relativity is a task with a similar magnitude to the implementation of the RBRVS itself.

#### **4. CMS Concern - Unwarranted payment disparities**

In the 2015 Final Rule, CMS noted that payment disparities exist within practice expense because E/M services reflected in global periods generally include higher PE values than the same services when billed separately.

To prove their point, CMS notes the clinical labor time for separately-reportable E/M codes includes a staff blend listed as “RN/LPN/MTA” (L037D) and priced at \$0.37 per minute, whereas some codes with post-operative visits include the staff type “RN” (L051A) priced at a higher rate of \$0.51 per minute. As noted in the RUC public comments, this scenario currently only occurs 3% of the time in the more than 3,000 existing facility-only surgical global codes. Further, in each instance this clinical labor input was specifically reviewed and determined to be accurate and resource-based by both the RUC and CMS. Therefore, this example can hardly be used to justify dissolution of the global period, and changing these inputs would violate the mandate for valuation to be resource-based.

Furthermore, E/M services performed in a surgical global period often include additional, justifiably more expensive, supplies and equipment relative to standard, separately-billed E/M services. 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-operative visit. **The RUC agreed that there are numerous individual services currently bundled into the surgical service global period that will now need distinct CPT codes following the transition to 000-day global services. Therefore, we will form a joint CPT/RUC workgroup to discuss what would be needed in terms of new codes. We request that CMS provide a medical officer(s) to participate and provide feedback to this workgroup.**

CMS also raises concerns that the indirect practice expense allocated to the E/M visits included in global surgery codes is higher than that allocated to separately furnished E/M visits. Indirect practice expense payment is derived from the weighted average of the specialty mix that performs each service. Currently, the indirect PE related to the post-operative work for surgical services is correctly derived from the costs associated with the surgical specialties performing the service. Under the transition, this same post-operative indirect practice expense would be inappropriately diluted due to the broad mix of specialties with lower practice expense per hour that perform separately reported E/M services. The unbundling of post-operative E/M visits would result in a decline in indirect practice expense payment for many specialties due to an inappropriate, artificial reduction of the indirect PE resources for post-operative services. The RUC agreed that this issue is difficult to model, since only CMS has certain inputs necessary to fully calculate the indirect PE RVU for individual CPT codes. **Therefore, in an effort to be**

**completely transparent, the RUC requests that CMS model the indirect practice expense impacts under the transition. Stakeholders need the proper tools and advance warning to fully assess the impacts resulting from these changes.**

#### **5. CMS Concern - Incompatibility of Current Packages with Current Practice and Unreliability of RVUs for Use of New Payment Models**

CMS states as their final argument that work RVUs will likely be used as the building blocks to develop a number of new payment models. Therefore, the Agency believes that it is critical to ensure that the Medicare payment schedule accurately reflects resource costs for individual services.

The RUC disagrees that the need for developing, testing and implementing new payment models precludes the use of the current surgical global period payment structure. If CMS maintains that payment inaccuracy is inherent to the current surgical global package, the use of alternative payment models argues for specific pilot testing, rather than a one-size-fits-all approach. As is the case with any new payment model, development and testing must take place in a controlled environment, in order for the effects of the policy to be fully understood prior to universal implementation. This should also be the case if the Agency is going to move forward with this transition policy. As we explained above, CMS could implement a limited roll out of a small subset of codes deemed by the Agency to be of high concern. This way, the policy could be evaluated by both the Agency and public stakeholders to better inform everyone involved as to the impacts and effectiveness of the transition.

#### **Additional Concerns raised by the RUC**

##### Multiple Surgery Payment Reduction Policy

During the January 2015 RUC Strategy Session, the RUC and other stakeholders discussed CMS payment reduction policies that impact the 010-day and 090-day global procedures, including the multiple surgeries reduction, bilateral payment reduction, co-surgeons and team surgeon payment reductions and the assistant-at-surgery reduction, and noted that many of these reductions are largely based on and justified by the redundancy of bundled post-operative E/M visits between multiple services or when multiple surgeons are performing the same surgery.

During this discussion, the RUC observed that a [CMS-commissioned study by Harvard researchers](#) in 1993 had performed a robust analysis of the physician work and time involved for multiple procedures. At the time, CMS used this study to justify major changes to its Multiple Surgical Payment Reduction policy. The 1993 Harvard study found that “for two service multiples, the marginal intra-service work and time of the second procedure is about 75 percent of that required to perform that procedure alone. For pre- and post-service work, this amount was 20 percent, suggesting significantly greater economies. We found economies of scope for total work to be, on average, 48 percent.” In other words, the Harvard Researchers discovered that, at the time, there was only 25 percent redundancy between the intra-service work of the second procedure relative to the first procedure. CMS based the updated multiple surgery payment reduction policy on these findings, which is still in effect to this day.

With unbundling, the ratio of intra-service work to total physician work for unbundled surgical codes would greatly increase and correspondingly greatly reduce the potential redundancy when multiple surgical codes are performed for the same patient on the same day. **Therefore, the RUC agreed that CMS should again analyze payment reduction policies that impact 010-day and 090-day global codes in detail, as it last did 22 years ago, and should update payment reduction policies appropriately based on these new analyses.** Furthermore, the RUC agreed to form a workgroup to evaluate the multiple surgery payment reduction and determine how the payment reduction should be modified in the event of unbundling of the surgical global period.

#### Professional Liability Insurance

Another consequence of the CMS decision is the large redistribution of Physician Liability Insurance (PLI) payment away from the primary providers of surgical procedures and into a more diverse group of providers. The PLI RVU for each service is calculated by multiplying the work RVU by the specialty risk factor of the specialty(ies) who perform the service. Currently, the work RVUs of the proxy E/M services contained in the global period for 010- and 090-day surgical codes are part of the PLI calculation. This valuation is appropriate because the liability costs of a specific service should be derived from those of the performing specialties. However, under the CMS proposal, the liability costs associated with the post-operative work would be removed from the primary service and would be artificially diluted by the wide mix of specialties with lower risk factors performing E/M services. The attached report contains two examples of this arbitrary decrease in PLI RVUs.

**The RUC agreed that a new PLI methodology that is resource-based and attributes costs fairly will need to be created prior to the elimination of surgical globals.**

#### **Conclusion**

While the RUC and CMS share the same goal to ensure physician services are accurately valued, the RUC strongly disagrees with the Agency's transition policy. Despite this, the RUC remains committed to doing the hard work of accurately valuing surgical global codes in an appropriate timeline. **This is why the RUC voted unanimously to potentially add additional meetings or extend the length of scheduled meetings, to accommodate the review of thousands of surgical global codes.**

In addition, the RUC implored CMS to consider the cost, both monetary and time, that this review will have on medical specialty societies and their physician and health care provider representatives. Based on meeting attendance data and recent cost data provided by specialties, the RUC estimates that the AMA and specialty societies in aggregate currently spend **\$8 million dollars per year** to participate in the RUC process, including staffing, travel, room and board, consulting and other expenses. This figure does not take into account the volunteer service provided by hundreds of physicians and other health care professionals that participate in the RUC process each year. The RUC may identify potential data sources that may benefit the review of these services and we believe that CMS should financially support such data acquisition under the funding made available via the Protecting Access to Medicare Act of 2014.



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The RUC appreciates the opportunity to have open dialogue with CMS over this extremely important policy. Furthermore, the RUC implores CMS to give stakeholders the proper time needed to fully vet the important issues listed above. Rolling out the policy in a controlled manner, allowing for pilot testing and sufficient time for the RUC to conduct a proper review of services would show the stakeholder community that CMS values getting this policy right.

Sincerely,

A handwritten signature in cursive script that reads "Barbara S. Levy MD".

Barbara S. Levy, MD

Attachments

cc: John McInnes, MD  
Edith Hambrick, MD  
Ryan Howe  
Steve Phurrough, MD