Data Collection on Resources Used in Furnishing Global Services Town Hall
CY 2017 Medicare Physician Fee Schedule Proposed Rule

Transcript of In-Person Session
CMS Headquarters
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Steve Phurrough: Good Morning, I'm Steve Phurrough. I'm a medical officer here in the hospital and ambulatory policy group. Let me welcome you to the town hall meeting on Data Collection on Resources Used in Furnishing Global Services. We're holding this town hall meeting to give stakeholders the opportunity to provide feedback on our proposal to collect data on global services from our CY2017 physician fee schedule proposed rule. The proposal is for a three-pronged approach to data collection: One is a claims-based data collecting on services furnished in the global surgical period, second is a survey [of] a representative sample of physicians, and third is direct observation of such services. Before we begin and I provide some ground rules, I want to introduce Carol Blackford. Carol is the Director of the Hospital and Ambulatory Policy Group, which has responsibility for the Physician Fee Schedule rule. Carol?

Carol Blackford: I'd like to add my welcome to Dr. Phurrough's and especially thank those who will be providing us with information and perspectives about our proposals for collecting data to use in proving the valuation for the global surgical packages. Given the number of codes and the wide range of PSS services priced under the packages, we believe improving the accuracy of these values is really a critically important part of including PSS relativity. Your presentations today will help us understand the impact of our data collection policy as proposed and how we might improve that. With MIPS beginning in 2017, January 2017, we recognize that physicians are being required to prepare and respond to a variety of initiatives coming out of CMS. Congress did mandate that we begin this data collection on January 1st, 2017, so we do not have the flexibility to delay the data collection but we do want to collect the necessary data while imposing minimal additional burdens. So I hope that you will share ways with us today how we can do this. Finally, I want to encourage everyone, including those participating virtually to submit official comments on the proposal though the rulemaking process. Through your input we regularly learn about the impact our proposals could have on your practice and the delivery of care and we often learn better ways to achieve our goals, so please take advantage of the comment period and submit those comments. I think it's particularly important in this case. So I won't take up any more of your time except to say thank you again and I'll turn it back over to Steve Phurrough, who as one of our medical officers in the Hospital and Ambulatory Policy Group he contributes greatly to our physician fee schedule policies. I'm sure many of you know him as a regular CMS observer to the RUC process and we value his contributions and thank you Steve for agreeing to help us with this town hall today.

Steve Phurrough: Thank you, Carol. Let me introduce the other CMS folks that we have here today: Dr. Ryan Howe is the Director of the Division of Practitioner Servicers who is responsible for the physician fee schedule. Immediately to my left is Kathy Bryant who is a senior technical adviser in the Hospital and

Ambulatory Policy Group. At the end of the table is Tourette Jackson who is an analyst in the Division of Practitioner Services. To my right is Patti Truant Anderson from NORC. She's been assisting us in putting this meeting together and she's our timekeeper so you'll need to pay close attention to her over the next hour and a half. We also have Barbara Wynn and Lee Hilborne from RAND who you've heard from and, if not, will hear from as part of the multiple data collection processes ongoing with global services. Now, a few rules of the road: This morning's session is to hear from those who are present, we'll have a session this afternoon to here from those who are remotely signed in. This morning we will not hear from those who are remotely signed in and this afternoon we will not hear from those who are present. You're welcome to stay and listen to the remote presentation this afternoon after our lunch break. For this morning's meeting, you'll have ten minutes to speak. We have eight speakers. You will speak ten minutes or less so that we can get all the speakers in before the end of the session. So you'll get a two minute sign that says you've got two minutes and at ten minutes we'll ask you to stop talking. I have a tendency to ask you to do that in the middle of a sentence, so please pay attention. We need to give everyone their amount of time to be able to make their own presentation. As you know, we are in a comment period. This is not a question-and-answer period. It is a time for us to hear from you and we are not able to make responses to your comments because we are in a comment period. If there is some time at the end of this session, some of those at the table may have some questions that we may want to pose back to you about your particular presentation, so there may be some questions that we will provide back to the presenters at the end of the session, depending on the time that's available after all the speakers. Like Carol, I want to encourage you to make your comments formal; submit the comments in the formal process for rulemaking. The comments today are not formal comments; they are informal comments to help us in assessing where we ought to be. If you want your comments to be taken formally, you need to submit them though the comment process. The comment period ends September the 6th, so you have another two weeks, not quite two weeks to do that. And it would be great if some of you would like to submit them next week rather than on the 6th. It would just be wonderful. So with that I believe we are ready to begin. The first presenter is from the American Academy of Dermatology (AAD), Daniel Siegel. And you'll speak at the microphone there.

Daniel Siegel: Thank you, Steve. It's a pleasure to see so many familiar faces and put faces to some familiar names that are otherwise unfamiliar. My name is Daniel Siegel. I am the former President of the American Academy of Dermatology and I am representing that organization which represents more than 98% of practicing dermatologists in the U.S. and on an informal basis, I'm representing a million other physicians who are also practicing who also see Medicare patients. A brief bit about me, I've been practicing now for 30 years; it's the anniversary of finishing my fellowship 30 years ago this summer. I've been practicing a long time. When I finished training I would follow simple premises: You document what you do. You do what you document, and you report that which is medically necessary. Very simple. We used to use soap notes. Times have changed; things have gotten a little more complex. When I see a patient, and I am in the trenches: I split my time between private practice and academics. When I'm seeing patients I don't wear a watch. I don't track my time. I'm not looking at my watch. I'm looking my patient in the eye, face to face and we're having a discussion. I might be scrawling away a little bit of a note or someone's taking notes behind me to jog my memory later, but I'm not looking at my watch. I

don't think that's good medicine. That being said, I'd like to make some of the more formal comments now.

The American Academy of Dermatology strongly opposes the requirement of reporting the proposed G-Codes, which are unnecessarily burdensome on physicians. It is extremely difficult to keep track of all the care that gets provided to a patient in ten-minute increments. Reporting these G-Codes would be intermitted and unreliable since there is no reporting incentive, therefore the data would be of little use for determining the time or resources used. The AAD also would like to point out to CMS that the MACRA rule did not intend for you to require all physicians to participate in data collection to value global surgical codes. Congress authorized the use of a representative sample of physicians to gather information about services related to surgery and furnished during the ensuing global period. Hard stop there. Now, the proposed reporting requirement would also complicate the claim reporting process, especially for those physicians who use clearinghouses to process their claims. Many of the clearinghouses do not have the capability to process zero dollar claim line items. Many small and solo practices are not equipped to be able to collect the required data and this new unfunded mandate would create a significant financial burden on them to invest in more resources just to meet this additional unfunded mandate. In addition, the G-Codes that were developed by the RAND Corporation did not go through the code validation process by the CPT Panel and the valuation process by the RUC to ensure that the codes are able to capture all the necessary elements needed for the care provided during the global period. They were not tested or piloted for validity.

The AAD would also like to argue that the list of activities that CMS listed in the proposed rules typical of global visits is based on a flawed definition of what is typical because the intensity and time spent on these activities for different procedures vary significantly. These G-Codes will not significantly differentiate post-op visits to help with valuations of services. Furthermore, there are many discussions and consultations that happen through the average practice day that are not face to face with part of the global services with any event that the proposed G-Codes will not be able to capture. We as physicians spend a lot of extra time working with patient's care, talking to nurses, technicians and other staff members and consulting with pathologists, radiologists, other specialists, and with these consultations; they don't happen in one sitting when the patient is in the room with you, but at different times through the global period on many separate days. We recommend using the expert panel that already exists, the CPT editorial panel for the development of new codes, and the RUC for valuation of practice expenses and other resources, not an unproven, unvalidated process. In summary, we recommend that CMS comply with congressional intent and use a representative sample of medical records to determine all post-operative resources rather than establishing a new standard of medical record keeping and reporting requirements. I would like to thank you for listing to me and I would like to get some guidance as to which of the G-Codes I should report for my time here today.

Steve Phurrough: Thank you, Dr. Siegel. Our next speaker is from the American Academy of Ophthalmology, David Glasser.

David Glasser: Thank you for this opportunity to address you. I come to you as the Secretary of Health

Policy for the Academy and I have been a practicing ophthalmologist for the last 33 years. The Academy's first concern with the CMS data collection proposal is that it has the potential to negatively impact patients and increase administrative and cost burdens for both providers and the Medicare Administrative Contractors. Under the CMS proposal there would be a significant increase in the total number of Medicare claims. There will be millions of additional claims for the proposed G-Codes reported for each ten-minute interval. A single visit can contain three or more of these codes per claim. Any additional line on the claim form generates additional cost to providers, processers, and payers. Claim forms may even need to be revised to contain them. Many systems will reject these claims with these codes because they aren't going to result in payment for providers. In our sphere, more than 250 ophthalmic procedure codes will be affected under the proposed mandatory data collection provision. The G-Codes themselves will compete with new or revised CPT or ICD-10 codes for the attention of physicians and coders and will create confusion. And administrators will be required to maintain one coding system with Medicare and another for other payers. Requiring physicians to understand and utilize yet another new set of codes for Medicare is also going to be burdensome, costly, and time consuming. Implementation will require outreach and education to physicians on how to use the new codes, especially since they're used to using code 99024, which is currently used to report post-op care. EHR and billing software will need to be revised to handle the new codes and these will likely require additional charges to incorporate them into their programs. The way the reporting intervals are set up with fifteen minutes for the first interval and ten minutes for the subsequent ones is inherently confusing. A simpler system in which every interval is ten minutes would be easier to use.

Our second concern is that, at least in ophthalmology, the impetus for data collection is based on statistically flawed OIG studies, which should not be the basis for policy decisions. The OIG study used small samples of physician records and claims. For some they reviewed records of five or fewer patients. For cataract surgery they reviewed 100 cases, which sounds pretty good until you consider that there are two million cataract procedures performed annually. That's less than one hundred cases representing 0.009 percent of all claims. From that small sample the OIG found that only one third of the hundred cases reviewed may not have had the correct number or exact number of typical visits built into the payments. Cataract data, such as it was, actually shows that post-op care correlated fairly closely with the number of post-op visits paid for in the physician fee system. The payments in the MPSS for cataracts surgery 66984 is four visits. The OIG study in fact found a mean of 3.6 visits in this sample they reviewed. So, we look at this as being a pretty accurate representation. The OIG's conclusion was that the high global surgery fee did not reflect the number of office visits.

The Academy has met with some CMS officials and I think we came to the agreement that it was difficult to draw conclusions from that data. Looking at the specifics and the nuts and bolts of using this system brings me to another concern. RAND sent around vignettes for us; one of them was the cataract patient post-op who had high eye pressure and needed a little intercession to release fluid from the eye and bring the pressure down. The idea was to find out if it was easy to determine the right codes. And it was pretty easy in that because you were given the answer, we were told it took 26 minutes. I would have no idea in that vignette if I had spent 26 minutes or how many minutes I spent with that patient. As mentioned by the previous speaker, you know, I wear a watch but I am not looking at my watch when

I'm talking to my post-op patients. I'm looking at my patients and particularly if they have a complication. You don't want me looking at my watch; you want me focusing on the care that I'm giving. If we look, not at a simple procedure like cataracts where the post-op visits usually don't require additional interventions, but we look at something like trabeculectomy, which is a procedure done, most commonly for glaucoma done by a glaucoma specialist (code 66170). This is another 90-day global procedure. It basically creates a hole in the eye to lower the pressure. Not just any hole, one that lowers the pressure just enough so that the pressure is not high enough to create permanent damage to the nerve and not low enough to create permanent damage to the macula. It includes 9 level-3 post-op visits and 179 minutes for payment. This would take, nominally, 18 G-Codes, more likely two dozen or more, considering there are often other reportable services within the global period, such as injecting antimetabolites to reduce scarring and prevent eye pressure or preparing and injecting autologous blood to increase the pressure and prevent damage due to low pressure. Many patients need one or more of these interventions. If you think about it, when we're seeing a post-op patient, if we need to do something like this it often involves moving the patient to another room, getting equipment or supplies. Am I going to do that? Is the tech going to do that? Am I going to see another patient in between? The answer is it is going to depend from day to day on the workflow on that particular day. So it's virtually impossible to differentiate, track, and determine the specific time allocations for physicians in these cases. In a typical glaucoma practice, these services are provided multiple times a day and can take up to a third of the appointment slots during a busy clinic session.

With the new system surgeons will have to stop after each visit, add up the amount of time, determine the complexity of the visit, and calculate the number of codes to report. Calculating that time and interpreting the criteria is an unnecessary interruption of workflow and an intrusion that interferes with patient care. We should be taking care of our patients rather than adding up minutes for administrative purposes. So when all is said and done, will physicians report these codes accurately? My experience working with many of our members on reporting requirements for PQRS and meaningful use where failure to report had more immediate financial consequences than this proposal, strongly suggests that the path of least resistance for most physicians is to skip reporting the G-Codes all together or to report a single instance, regardless of the amount of time spent. So adding a new, complex, time-consuming requirement on top of pre-existing coding complexity guarantees both underreporting the number of visits and the amount of time spent delivering care.

So, to summarize our concerns with the proposal: it increases administrative burden on clinicians; it adds additional practice expenses with no additional compensation; it requires implementation of a confusing, complicated new system at the same time that a new Medicare payment system is going in effect, which will also require the physicians to learn other new payment conditions and relationship codes. There's no viable mechanism for measuring time. There's inadequate time to learn and implement the new G-Codes. There's unnecessary complexity related to the initial and follow up time intervals. There's built-in bias for underreporting. There has been no pilot testing and the premise for the data collection is flawed. I didn't come here just to whine, so we have some proposals. We recognize that CMS is required to collect data on provision of post-op services. We believe that the legislation only requires that a process be in place and not that data collection has to begin in January. We believe in

working with the surgical community to find a better way to collect this data from a representative sample rather than all cases can be found. The second and third phases of the data collection should be conducted first and information derived from those physician surveys and direct observation studies should be used to determine how to collect data from a representative sample and how to interpret it. Use of existing CPT 99024 and appending the appropriate modifier to designate level of service would be simpler, more logical, and easier to teach and more likely to be accurately adapted. And finally, study a subset of procedures. The RUC put forward criteria that I suspect you will hear later today that would be a good starting point to streamline the number of procedures reviewed by focusing on high volume commonly performed procedures. This would reduce the number of ophthalmology services to be reviewed from over 250 to approximately 33. The Academy supports the RUC criteria and would work with CMS to develop a more rational system to collect the required data on the number and level of post-op visits, thank you.

Steve Phurrough: Thank you, next we will hear from the American Association of Neurological Surgeons, Katie Orrico.

Katie Orrico: Thank you very much for the opportunity to be here, my name is Katie Orrico and I'm the Director of the Washington office of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons and we appreciate the opportunity to provide you with comments. As a general matter, neurosurgery believes that the goal of accurately valuing global surgery services can be achieved without completely overhauling the existing coding structure. While neurosurgery will submit detailed comments responding to the specifics of CMS's proposal, I wanted to take the time here to provide you with the findings of a global surgery survey that the surgical community launched seeking feedback from practicing surgeons, and copies of this survey and the summary of the findings have been provided. Surgeons and physicians from approximately 25 other specialties participated and as of today we've received about 7,000 responses although the data here were captured as of Sunday, so they're not as complete as they ultimately will be.

Briefly, the demographics represented a pretty good representation across the country. About half the respondents were in private practice, but all types of practices were represented including private practice, academic, hybrid, private academic institutions, and physicians who are employed by hospital systems. More than 40 percent were in solo or small single specialty practices, so it's critical CMS take into account the additional administrative burdens this data collection effort will have on these physicians in particular. About a third were in the South and the rest of the respondents were roughly evenly distributed to other geographic regions in the country. And most of the surgeons who responded were in urban or suburban areas which you'd probably expect. According to the 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 in their practice operations. Some of these include: developing new methods for tracking and collecting global surgery work, making modifications to their EHR or billing systems, incurring additional staff and physician time spent on tracking, and processing global surgery information into EHR and billing systems. Additionally, just under one half of the respondents anticipate that they would have to hire

new staff or purchase additional software to capture global surgery services under a new G-Code system.

Incorporating new G-Codes into surgical practices will require surgeons to make changes in the manner of which they operate and record the flow of their practices. Examples of this include: developing new pre- and post-operative visit tracking and patient engagement forms, developing methods for transferring visit data from one treatment site to another or back to the office, differentiating Medicare patients from others so that they're not overly collecting information on every single patient that they're seeing rather that they're complying with the Medicare requirement. Some physicians would find it necessary, if they haven't already done so, to hire scribes or some other mechanism for folks to shadow the clinicians to document services and using additional technology such as handheld devices or stop watches to track the time spent. All of these practice changes will come at a significant cost to our surgeons. 40 percent of respondents anticipate it will cost them between $25,000 and $100,000 and another 30 percent estimate they will spend more than $100,000 on compliance. These costs include modification to EHR and billing systems, staff costs, loss of productivity, and the like. While CMS and its contractors might be able to simply flip the switch to incorporate the new G-Codes into their claims processing systems, not surprisingly, nearly ninety percent of surgeons foresee physician compliance problems with the new surgery G-Codes. The striking findings support our contention that this all-physician, all-service claims-based approach is the wrong way to go and will not in fact produce useful and valid data.

Finally, a supermajority of surgeons believe G-Codes is not an appropriate method for collecting surgery data and when asked for suggested alternatives for the G-Code approach, a common theme emerged. One neurosurgeon who is employed by a hospital in a small Midwest practice tells us, "Leave it as it is. It's a global period. Each patient receives as much care in the post-operative period as is required. Starting to track these G-Codes will kill efficiency and further discourage my treating patients in Medicare." Pointing out the administrative burdens of the proposed G-Codes, an orthopedic surgeon in a small private practice in the West implores, "Why fix something that's 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 patient's room or see them in my office. More administrative nightmares—how much more does CMS expect us to take?" An ophthalmologist in a private practice in the Midwest wisely noted, "Surveys are routinely performed for specific codes to determine this information. Thinking that mandating a new code to be used when billing will give more valid information is folly." And finally, reflecting the frustration expressed by many surgeons that were surveyed, an OBGYN in a private practice in the Northeast exclaimed, "Do not try fix a system that is not broken. Enough is enough already." We hope you heed these findings of our survey as you finalize the process for reviewing the accuracy of global surgery codes. As always, we stand ready to participate in a collaborative and constructive process for seeing this through. I thank you very much for your attention today and I'll be available to answer any questions should you have any. Thank you very much.

Steve Phurrough: Thank you. Our next speaker is from the American College of Surgeons, Linda Barney.

Linda Barney: Hello, I'm Linda Barney, a practicing general surgeon and Vice-Chair for the American College of Surgery, General Surgery Coding and Reimbursement Committee. We appreciate the opportunity to provide feedback on resources used in furnishing global services. We are disappointed that CMS has proposed a policy to collect data from all physicians who perform 10- and 90-day global services using the eight newly created G-Codes. Most physicians will not be able to comply with this requirement by the implementation date of January 1st of 2017, which will result in CMS not being able to collect accurate and usable data. Instead of moving forward with the proposed data collection policy using G-Codes, we urge CMS to proceed slowly by first developing a sound survey methodology. If CMS intends to move forward with claims-based collection, we urge the agency to start by using the existing CPT code 99024 instead of the proposed G-Codes. If collecting accurate data is not possible by January 1st 2017, we support a decision to spend more time further developing this policy with input from specialty societies. We suggest consideration of a graded implementation strategy to allow practitioners time to understand the process, software systems the opportunity to develop data capture within existing EHR technology, and a pilot program to assess effectiveness of the proposed data capture process. This would create a foundation and allay concerns that a more substantial rollout will collect the appropriate data in a reliable and validated method.

CMS should not implement the proposal to collect claims data via G-Codes. This proposal to collect data from physicians using G-Codes reported in ten-minute increments with different codes intended to distinguish intensity is completely untenable for the practicing surgeon for a number of reasons: First, the proposed time-based codes are not aligned with clinical workflow. The burden associated with physicians attempting to track their time in ten-minute increments is onerous and will result in underreporting of data. Requiring the reporting of ten-minute G-Codes in real time would disrupt clinical workflow and take away from patient care.

Second, CMS's definition of a typical visit requiring reporting of the GXX1 or XX5 does not incorporate complexity, medical decision making, or other elements of the care associated with providing these services. According to the proposed rule, any visit that includes an activity listed on Table 10 of the proposed rule is considered typical. However the work, time, and intensity associated with these activities can be drastically different. To report considerably different services using the same G-Code does not accurately capture the full scope of difficulty associated with these activities.

Third, the proposed G-Codes lack validation. The AMA has an established and well defined process for developing G-Codes to report procedures and services, often including significant guidelines to describe what is included in the work and correct reporting. The proposed G-Codes should not be used because they have not been validated, tested, nor shown to be reliable. Finally the data collected by G-Codes is not comparable with existing E/M services assumed to be bundled into the global surgical package. If CMS were to proceed with this policy, the agency would have to somehow take the data collected from three levels of G-Codes for typical, complex, and critical care services and crosswalk it to the existing three inpatient, five outpatient levels of service. E/M coding practitioners are familiar with coding systems already in practice. Efficient means of data capture would be existing claims using coding and documenting methodology that clinicians already understand. Accuracy would be enhanced by a system

that requires simple code education and familiar processes and audits that would not interfere with the normal flow of business during the data collection period.

The next area I'd like to discuss is CMS's decision to collect data from all physicians who report 10- and 90-day globals instead of from a representative sample of physicians. The language of MACRA is clear that CMS should collect data from a representative sample of physicians, not from all physicians. CMS indicates in the proposed rule that the agency is unable to identify a representative sample given that it does not have enough information on how post-operative care is delivered, how it varies, and what drives variation in post-operative care. We believe it is possible to identify a representative sample that will result in statistically reliable and valid data without requiring reporting of all physicals who provide 10- and 90-day services. We urge CMS to work with stakeholders to develop the appropriate data capture and survey methodology.

If CMS does plan to move forward with claims-based data collection, we make the following recommendations: As mentioned previously, CMS should select a representative sample of physicians from whom to collect data. CMS should not collect global codes data from all physicians. CMS should select a represented selection of physicians to include various geographic setting, practice times, sizes, and specialties. Creating a large enough sample with broad utilization across geography, relevant specialty, practice type, and location will allow mitigation of variability in data for analysis. Instead of using G-Codes, CMS should require the representative sample practitioners to report one 99024 CPT code for each post-operative visit that they provide within the 10- and 90-day global period. In this way CMS will capture data on the number of post-operative visits provided. This is the least burdensome option for collecting these data via claims-based reporting because 99024 is a current CPT code that many physicians are already required by the institution to report. Outpatient EHRs are already able to capture this code. This would be more intuitive and straight-forward than the G-Code option for physicians and EHRs which would lead to more accurate data collection for CMS. If CMS believes the agency is required to collect data on the actual services provided in post-op visits and the level of services, we recommend CMS instruct RAND to conduct a more in-depth follow-up survey to collect data on the work that goes into the surgical global. We do not believe that there is an accurate way to collect data on the level of visits, intensity of work, and resources utilized via claims. We encourage CMS to focus the data collection on the E/M levels rather than developing a new construct for assessing level of service. E/M codes are valid and vetted.

In follow-up surveys, we also ask that CMS collect information on additional services that physicians provide in the global period that are not captured by E/Ms. Operational simplicity requires use of data collection that is familiar to providers, systems, and analysts and can reasonably ramp up in a short implementation window—a system that would not interfere with the parallel ongoing business of medicine, that would impede patient care and threaten economic viability of many practices. Data collection is not more burdensome than existing documentation and billing standards, especially in light of the significant data capture needed as clinicians are transitioning to MIPS. Process familiarity such as standardized coding nomenclature, established claim forms, and survey methodology.

With respect to timing, the data collection should start January 1st, 2017, based on two contingencies: First CMS mandate hospital EHR claims submission of 99024 for facility visits. Because reporting on facility visits is dependent on this capability, CMS should not implement this policy without ensuring that these facility claims can be submitted via hospital EHRs. This is the only way to capture facility visits, because the hospital EHR will be used to document these visits, not the office. Second, that CMS can guarantee that the agency has sufficiently educated all Medicare providers prior to the implementation date. In conclusion, we urge CMS only implement policies that result in accurate, valid, and reliable data. MACRA does not require that CMS start on January 1st, 2017 collecting all data from all physicians using claims. We do not believe that CMS will be able to attain accurate, comprehensive data using the currently proposed methodology. In fact, given the short time frame for implementation, it will almost certainly result in underreporting which will be harmful to surgeons, their practices, and patients. Thank you for the opportunity to provide comments during this listening session and we hope to be able to work collaboratively with CMS in the future towards a fair and accurate data collection methodology.

Steve Phurrough: Thank you. Next we have the American Medical Association/Specialty Society Relative Value Update Committee, David Hitzeman.

David Hitzeman: Thank you for allowing me to make comments on behalf of the RUC. I want to point out that my name is David Hitzeman and I'm a practicing internist. I am not usually involved in reporting these codes but my involvement in the payment system has been with the RUC and I've been with the RUC for 20 years. I fully understand the process of valuation within the entire fee schedule and I think that it is important that one thing we keep in mind as we go through this process, that I think it's important for the valuation process of the entire RBRVS that we know that there's dependency on data, that data needs to be accurate; it needs to be relevant. We need to use a similar process that when we do valuation that include the entire system because if we deviate from a certain group of codes, any certain specialty, we can certainly introduce significant distortion within the entire fee schedule and I think that's an important concept to keep in mind.

Let me first comment a little bit about the RUC. The RUC has been involved in valuation now since the beginning of the fee schedule in 1992. It has an enormous amount of data that it's collected. It's collected in all aspects, in components of resources that are required to value the codes. With specific reference to global services, the RUC has been collecting data on both the number and level of post-operative codes since its inception and has a very robust database. It also has a threshold of surveys that collects the data that makes sure that we're dealing with statistically appropriate number of codes as we look at our valuation. The process of the valuation takes a look at these surveys, the robust data that comes in with that, extant data when it's available. And then with the expertise of the panel is able to make appropriate recommendations and additionally make sure there's consistency with the process it develops throughout the fee schedule. If you look at what we are talking about primarily today, what is the number, what are the levels of appropriate services in the bundled codes, I would refer to the RUC database and say that the data that has been collected clearly shows the data indicates that the level of codes, 99% of the codes for the outpatient services, the 99212 and the 99213. 86% of the time in the codes that are involved in the hospital coding would be 86% are the lower level codes of 99231 and

99232. If you look at separately reported E/M codes, they are in the mean and median, higher than those levels of codes. So I think the process that the RUC has gone through reflects the appropriate nature of the level of coding, which is based upon a concept which is E/M codes, which goes throughout the entire system, is well understood by physicians, and is well understood by the surgeons, because they use these codes when they do non-surgical E/M services.

It also is important to remember that one of the basic tenets of the fee schedule is we look at valuation; we're looking at the typical patient. What we see introduced in the G-Codes that are being presented are introducing this concept that there is an additional code or data that needs to be based upon intensity. If that is introduced, in my opinion, that will potentially have some influence in a negative way upon the rest of the fee schedule that does similar services that are E/M services. Now, CMS has indicated in the past that they don't think that the E/M services as described appropriately represent the work done in the post-operative period. The RUC truly disagrees with that and I think that physicians are well aware, as has been stated before, the description of E/M services, how the E/M services are to be applied based upon the level of history, physical examination, and decision making and that is what determines the level, not based on time. Introducing time into this process is totally against all of the coding conventions that deal with E/M services. I believe, and I believe most physicians say valuation and management, by definition is going to be very similar, obviously, as far as the components when you are dealing with the post-operative patient or dealing with the patient in the medical situation.

Speaking directly to the concerns I think the position that CMS is taking in the valuation processes using G-Codes, I offer a number of comments: I think, when you look at the number of codes in the proposed rule is requiring all physicians reporting on all 10- and 90-day global services that use G-Codes. There are over 4,000 10- and 90-day global services within the fee schedule. The majority of those are very low volume, adding to the burden to do this on all codes is not going to be very accurate, it's going to be in my opinion, and the RUC has seen that when we've looked at codes that have low utilization, that it's very difficult and sometimes impossible to get a good representation. At the end of the day, these infrequently valued codes, infrequently used codes will have very little impact on the fee schedule. Again, if you look at the analysis of the E/M services that exist in the fee schedule, clearly I think that it's accurately described, and well understood by the physicians that using the existing E/M service descriptions to determine what level; there's no reason to continue replacing this with the G-Codes. The other problems that I said before, that E/M services are not time-based. You're now introducing the potential institution of ten-minute increments. As we as physicians see patients, we're not looking at increments. As we determine the level of service that we give in the E/M environment is determined upon the components I talked about. What is the level of history, physical, and medical examination decision making that determines and includes them in the complexity of the decisions that are being made? So by separating out the G-Codes by typical and complexity I think that that's going to make these services, services fundamentally different from the E/M codes and the surgical global and could, again, through the schedule, provide some distortion with the other services.

And perhaps the greatest weakness in this whole process is that these G-Codes, is the inability to match them with E/M services, which are soon to be bundled into the current surgical global package and it

really is not clear how the agency is going to take this raw data that is generated by the G-Codes and use them to assess the exiting E/M services and by redefining the parameters of these post-operative visits, CMS has created a scenario which leaves the actual task of insuring the surgical services are appropriately valued extremely difficult and non-transparent. Also, requiring that all physicians use these codes on all 10- and 90-day globals as said by many folks is extremely burdensome and very costly. Analysis by the RUC staff when they looked at the physician files from 2015, if we were using G-Codes and were reporting them on the services, that would require about 450 million codes being submitted and the cost of that has already been described. CMS's proposal to collect data for all physicians of the greater than 4,000 codes is, we believe, counter to the intent of the MACRA legislation and which mandates the use of a representative sample.

I would also say that MACRA is also clear that it wants to reduce administrative burden, so requiring every practitioner to report these codes will be in many ways less representative than a target sample, as compliance may vary based on practice size and other factors that have already been described. Due to the burdensome nature of the reporting there is a very high probability that there will be underreporting of these services. So in summary, the complexity and the burdensome nature of the Agency's proposal is in contrast to both the understanding of relativity within the global bundle and the scope of the legislative mandate as laid out in MACRA. Now, what is the solution? The solution is going to be provided by Dr. Anderson on behalf of the AMA and I believe that I would ask that CMS would clearly and closely look at these alternative recommendation for gathering the data that needs to be gathered and I would place that and have him present that to the committee when it's time for him to speak. Not in addition to the fact that we feel that the use of these bundle codes is totally inconsistent with the valuation process that already exists within the fee schedule. Thank you.

Steve Phurrough: Thank you, Dr. Hitzeman. Our next speaker is from the Society of Thoracic Surgeons, Josh Krantz.

Josh Krantz: Thank you for the opportunity to comment regarding proposed data collection on resources used in furnishing global surgical services. My name is Josh Krantz, Political Affairs Manager for the Society of Thoracic Surgeons. STS represents more than 7,000 cardio-thoracic surgeons, researchers, and allied health professionals who are dedicated to insuring the best surgical care for patients with diseases of the heart, lungs, and other organs in the chest. We are disappointed with CMS's proposal to mandate data collection from all surgeons on all pre- and post-operative visits and resources used in furnishing global services, as it contradicts statutory language that authorizes this type of data collection from a representative sample of surgeons. Furthermore, the complexity of the plan as proposed will create undue administrative and financial burden on physicians and their staff and have deleterious effects on patient care with very little benefit to actual payment accuracy. The existence of an ongoing support for these global surgical packages represents a long established commitment to surgeons by providing all necessary care during the global period. The surgical community recognizes the need to ensure the global surgery packages are reflective of the care provided during the course of a physical surgical case.

CMS first proposed studying the global surgery packages by unbundling them, which would have forced surgeons to bill for each individual pre- or post-operative formally covered under 10- and 90-day global payments. Congress saw this as potentially harmful to patient care and though the Medicare Access and Chip Reauthorization Act instructed CMS to leave the global services packages intact. While MACRA prevented CMS from finalizing its initial proposal, it allowed for a presumably less destructive mechanism by which the agency may study services provided under the global surgery packages, collecting data from a representative sample of surgeons. In the proposed rule, CMS has gone far beyond representative sampling. CMS has instead proposed three diverse ways of implementation of congressional intent: One, mandatory reporting by all physicians in ten-minute increments for all procedures covered by 10- and 90-day global payments. Two, surveys of 5,000 clinicians related to services provided for 10-day and 90-day global codes. And three, in-person observational time studies on a sample of providers conducted by RAND Corporation.

STS believes CMS's proposal to collect global surgical service data from all surgeons using G-Codes will not paint the clear picture of care provided during the global period as that care is greater than the sum of the parts defined in the proposed rule. The new set of G-Codes, totally unfamiliar to providers and never before tested, will not capture the care coordination between the surgeons and residents, pathologists, nurses, and other providers, which all represent non-trivial aspects of surgeon work. The realities of a surgeon's workload are not conducive to the ten-minute segmented billable hour structure proposed. Simply put, there is no evidence that validates CMS's proposed method of measuring time and work flow of the surgeons. Implementation of this proposal's complex set of G-Codes by January 1, 2017 is a near impossible task with a totally unrealistic timeline. Educating our membership for implementation will be a significant hurdle, given that these G-Codes will be entirely foreign to most of our members. Successful implementation goes far beyond the education of providers and also must include putting systems and processes in place to capture these codes and submit them on claims. As surgical care may take place over a 10- day or 90-day time, multiple claims may need to be submitted under CMSs proposal. It is unrealistic to think providers would wait 90 days post-procedure for a claim for services provided months earlier.

Additionally, linking subsequent post-operative G-Codes to the previously submitted procedure done weeks or months earlier will prove challenging. Both small practices and larger health systems alike will struggle to put the correct infrastructure in place to capture these new data. It is certainly a considerable financial burden. Recently collected survey data from a broad range of surgical specialties demonstrates this point. This new administrative burden, especially as surgeons are getting used to new requirements under MACRA will be overwhelming. We believe that a physician's time and resources are best spent caring for patients rather than accounting for work in ten-minute increments. STS is concerned that this proposal will contribute to increasing rates of physician burnout. This additional burden that CMS is placing on physicians is another example of administrative load placed on providers' shoulders with no demonstrable benefit to patients. It is not clear to us how this reporting fits into all the other programs that CMS proposed this year, including mandatory bundled payments for coronary artery bypass grafting.

STS recommends that CMS create a representative sample of surgical services using the following criteria: Medicare volume of at least 10,000 and/or $10,000,000 in allowed charges and at least 100 separate physicians performing the procedure. The sample should include medium and small practices, not just large hospital-based practices, which often represent modified practice patterns which are different from the majority of practicing physicians in suburban and rural areas. STS recommends CMS collect the level of specifically identified high volume and broadly performed surgical procedures by a process separate from claims reporting. In conclusion, SCS is disappointed that CMS has proposed a burdensome initiative to ameliorate a perceived problem. The agency should start with a data collection process that is limited in scope and utilized as a true representative sample to better understand post-operative visits and other elements of care provided in the post-operative period. Thank you.

Steve Phurrough: Thank you. Our next presentation is from the American Medical Association, Allan Anderson.

Allan Anderson: First of all I want to thank the RAND Corporation and CMS for putting this time together so we could come here and offer testimony before you. Just a few personal things. My name is Dr. Allan Anderson and I actually work here in the state of Maryland. I have an office over on Eastern Shore but work for a company called Integrace doing predominantly dementia care. I've also been part of the AMA RUC process now for about nine years. That would probably still make me a junior member of the RUC. I've also been a member of the subcommittee that has recently been looking at the surgical global issues. I'll just take a moment before I get to the RUC's recommendations to just talk about the RUC in general and some of my impressions about this issue that has come before the RUC and has been dealt with by the subcommittee.

First of all, it's been a privilege to be part of the RUC. Sitting around that table, there are a number of very dedicated and passionate physicians and they're not here to advocate for their specialty. ABD advisors are, but the RUC isn't. The RUC is there to advocate for what makes sense for medicine and moving medicine forward in a way that doctors can still enjoy practicing medicine. They volunteer their time away from their friends and family, their practices, to go to meetings, to attend committee meetings, which often occur between RUC meetings, and yes, we do have RUC homework, so we actually do homework before each RUC meeting. And these individuals certainly make up, I believe, the sentiment of what I'm presenting today. Basically in the subcommittee I remember, unanimously, everyone who was in that subcommittee thought that this would be an onerous and burdensome process if it was applied to physicians billing these codes. And it made me think about something coming here today, and that is that these are experts, these are people that knew coding and documentation backwards and forwards. I want to think of the rank and file doc out there who might not be very expert tackling something this complicated. I can't imagine, for members of this RUC subcommittee, that you're going to get adequate data by forcing those doctors to engage in that process. So I want you to keep that in mind. I'm not here to complain. I'm actually here to also bring forth some recommendations from the RUC.

So the RUC recommends that the best way to validate the visit data included in the surgical global

validation is through a significant survey, as you recommend in your second prong approach, rather than via claims data. We do not believe that the statute requires you [to] collect this information through claims data; however, if you do proceed, the RUC has a few specific recommendations regarding how to move forward: First, the legislative intent is clear that it mandates the use of a representative sample. As Dr. Hitzeman conveyed earlier, as many of the surgical services in the payment schedule have low Medicare volume, CMS should limit its focus to services which have the highest likelihood of collecting meaningful data. The RUC reviewed publically available 2014 Medicare data and identified a set of criteria which would focus on the collection process on a wide range of relatively high volume surgical services commonly performed by physicians across the United States. The criteria are as follows: One, Medicare volume of at least 10,000. Two, and/or $10,000,000 in allowed charges, and three, at least 100 separate physicians performing the procedure. These criteria identify 235 codes that are primarily performed by 20 surgical specialties. The RUC recommends that CMS limits its data collection to services within this set. Recall that the recent RUC database is based on responses from 76 physicians on average, so it would make little sense to collect data on CPT codes via the claims process for services performed by fewer than 100 physicians in the U.S. Regarding identifying a representative sample of physicians, CMS should select a sample to include various geographic settings and practice types. CMS should begin by reviewing the physicians who perform these 235 or a subset of those higher volume services.

Second, the RUC recommends that 99024 be used in lieu of the proposed G-Codes. This code is defined as Post-operative follow-up visit normally included in the surgical package to indicate that an evaluation or management service was performed during a post-operative period for a reason or reasons related to the original procedure. The RUC supports the use of this CPT code, again 99024, because it is currently included within Epic and other EHR platforms for internal purposes. The availability of large sets of data on 99024 has been confirmed by several large physician group practices including Mayo Clinic and Kiesinger. We want to emphasize that 99024 should be reported only once per visit and not in ten-minute increments. As Dr. Hitzeman stated earlier, asking physicians to document your time in ten-minute increments is completely untenable. We've also heard from several other people who testified to that as well.

Finally, we recommend that visit levels be collected via the survey process while the law states that the level of visits must be validated, it does not need to be collected though claims data. Given that there is relatively little to gain from collecting this information, CMS should collect the level of visit data as part of its broad survey of practitioners. A blended use state would be conducted by RAND. We believe that the RUC recommended approach is preferable for two important reasons: First of all, it allows CMS to focus limited resources on high-volume services while also giving the agency valuable data on the reliability of surgical package valuation overall. And two, it limits the administrative burden on physicians, which also increases the likelihood of compliance by these busy practicing physicians and truly, what kind of data might you get from them?

So, in summary, the RUC along with others present, would like to work with CMS to look at a better way to value this, a better way to look at these surgical globals so that we can all move together to fixing this

problem and answering your questions. Thank you.

Steve Phurrough: Thank you, Dr. Anderson. That concludes our scheduled speakers for this morning. Do any of our CMS folks have any questions they'd like to ask the presenters?

Kathy Bryant: We do.

Steve Phurrough: Alright, Dr. Howe.

Ryan Howe: I thank you all very much for your thoughts and I was particularly impressed with everyone getting in under time. Sometimes I've had problems with that, so I certainly appreciate that. I have one question, one recurring theme that we certainly heard and have is to look at the highest volume 250 codes or something like that. We also thought about that and I'm not sure how much of this we articulated fully in the rule, but one of the concerns we had in looking at just the high-volume services is one, if you look at, say, the top few hundred codes and you consider how many of those are done in volume relative to the other 3,700 services, what percentage of post-operative visits are you essentially requiring reporting on fundamentally? We had some concerns about whether or not the burden would actually be greater on requiring reporting on the vast majority or but there's an exception list essentially for the 3,000 codes that are, remember 3,000 that have the lowest volume. Basically, are we creating a circumstance where at every post-operative visit there has to be analysis that goes on and says, well is this post-operative visit associated with this procedure or that procedure if both procedures are performed at the same time? If you have concurrent surgeries and one of them is on the high-volume list and one is one the low-volume list, do you report that? And then what do we do in data analysis downstream? Do we assume there's some post-operative visit going on that might not have been reported because it was associated with a concurrent surgery that was on the low-volume list not the high-volume list? I would be interested in thoughts on what's the tipping point for post-operative visits that need to be reported on. Does it actually make sense to exclude the post-operative visits associated with the low-volume service or is that process an easy to say, this post-operative visits is associated with this low-volume code and so we don't have to report that? Is that easier than we think that is? That sort of, both of those are my questions essentially. What about the burden of figuring out which code is on which list in order to report post-operative visits or not? And from an analysis perspective, downstream, in terms of valuation, what to do with concurrent surgeries, and if we don't have data about the post-operative visits on the concurrent surgery but we have it on the one, how do we exclude?

Kathy Bryant: Just to add to that, we were looking at both surgeries that were done at the same time as well as surgeries that might be done within the same 90-day period and sort of linking them together.

Steve Phurrough: So any responses to that from the assembled group? Please stand and talk to the microphone and identify yourself again.

David Glasser: David Glasser, the American Academy of Ophthalmology. As to the question of whether it's easy for the physician to identify whether the post-op visit is associated with the high-volume or low-

volume surgery, I think that's pretty intuitive—it's a lot easier than figuring out the time. You have the numbers, you can probably look at what percentage of post-op visits you would be looking at if you excluded all the cases where there simultaneous or concurrent surgery, and if that number is still a significant percentage, that maybe good enough. The other thing you could do is phase two and phase three first and then you would have some direct knowledge as to how those post-op visits are going and you could use that to inform decisions about which codes to include and which not to include.

Steve Phurrough: Any other responses? Dr. Hitzeman are you coming to the microphone?

David Hitzeman: I would just say that I have the perspective of using this approach that we are discussing in concert with how we are looking at miss-valued codes throughout the fee schedule. We've been looking at them in segments we can actually get good data and moving on, we can actually use our responses and our experiences with how that data is collected and then moving on to the additional codes, dealing with the ones that are most important in the schedule because of their volume and the cost of Medicare. I think the other point of this is we're really looking at the number of visits, I think that we have a good explanation that the level of visits is well described and well understood in the data that is available. So the number of visits is what is important and can there be some validation at least with that subset of services, of what exists within the fee schedule that are embedded in the fee schedule and you can then make some assumptions if it's validated at that level. Then the other codes, based on the survey process that has been conducted would have some validity. I think it's a work in progress and I think the concept of trying to take on all codes of all varieties is going to be a daunting task for physicians and for CMS itself. Thank you.

Steve Phurrough: Other comments on those particular questions? Other questions?

Kathy Bryant: Okay. Ryan asks the big questions, I ask the little ones. That's our division here. So there's been a lot of support for using 99024 but Dr. Siegel, you mentioned a lot of the clearinghouses can't process no pay claims, so 99024 would still be a no pay claim. Correct?

Daniel Siegel: That is correct. Any no pay claim creates problems. If you try to put a claim for like one penny, you're still paying the cost of the claim to the clearinghouse which is another unfunded mandate expense. The one idea that was not in my formal comment was to think of it like an oil change. The oil change sign says 9.95 but they hit you up for a $10 toxic waste disposal fee. Why not give a dollar for every G-Code? At least cover some of the expense of this onerous work. It wouldn't cover it all. I still think we should get rid of these G-Codes and do it the correct way though CPT and RUC, but this is just a nightmare to private practices and we will be driving more of those people out of practice and into retirement if we can afford to do that and replacing them with less qualified practitioners.

Kathy Bryant: Perhaps I didn't ask my question right or I'm a little slow. I'm not clear if we use 99024, would they be able to process those and it not create a problem, or is there still the same problem?

Daniel Siegel: There's still the problem that a non-value code creates a problem, some bounce it back.

Depending on the clearinghouse, you're paying for the claim, regardless; you may be paying for the claim by the number of codes on there so there is an expense. If you're having long, detailed visits during the global period you incur extra expense every time, not to mention the time looking at your watch as you try to figure out how much time you've actually spent.

Linda Barney: I think PQRS, how they got around a lot of these issues is using a one-cent charge.

Sherry Smith: So then that creates an accounting nightmare for them and they have to go back and reconcile that. It's not really income that's coming in but there are still people, clearinghouses that require them to put one cent on those P codes for PQRS.

Daniel Siegel: And to build on what Sherry just said, when you have the reconciliation, someone in your office being paid a fair day's wage is spending time doing those reconciliations and at the same time calling up and dealing with rejected claims and dealing with errant claims rejections and other hassles of the day. It's one more unfunded mandate that's a burden on the practicing physician.

Ryan Howe: I guess just to follow up on that, along the same lines, I think it might be helpful for us to understand, it sounds [like] sometimes folks are talking about a real time accounting of the ten minutes: like you have to submit the claim after the first ten minutes and then talk to the patient and submit another claim. That's certainly not the intent. Rather each line of the claim in service units has an impact. It might be helpful to understand the burden relative to sort of the number of codes that go on a claim. If they're no pay claims, one might imagine that one could bill several services towards the end of a surgical period, as opposed to a daily basis and certainly not on an hourly basis. It might be helpful to understand the burden of doing that, of sort of reporting at the end on a single claim all of the different services that happened in the post-surgical period.

Steve Phurrough: If each of the speakers when they come up could reintroduce yourselves for those who are remote.

Dan Siegel: This is Dan Siegel. Picture the scenario of a post-operative day visit where you're seeing post-ops and consultations. I come in to see you and the chart doesn't have the path report back so I leave the room and say to a staff member, see if we can track down the pathology report. I then see another patient while we wait. Who's going to take a stop watch and say you spent three minutes looking at the wounds and then you spent a minute calling to a staff member and seeing if they could track the path report and you're hopping around. It's not, we're not like lawyers where you're sitting in these fifteen-minute increments that you round up and we're trying to take care of the patient. We don't think of the time like that. I would suspect all the other docs have days when you're doing multiple things, you're moving around, trying to function efficiently when the phone call comes in that the radiologist or pathologist called you up and your staff said doctor such and such is on the phone. You say excuse me; you talk to the patient who had been waiting because you need to discuss a result with them. You're back and forth. My mind doesn't think of saying two minutes here, three there-who's tracking all of this? It's insanity that's added to a day that's already made unpleasant by so many other

unfunded mandates over the past decade.

Linda Barney: I think in response to your question, the process is, you would submit your bill as soon as the service is provided. You wouldn't hold a bill 90 days to collect every encounter you might have with a patient over time afterwards. That would not be a functional system for submitting claims for physicians. Then at the end you wouldn't have a way to submit non-billable claims on a claims form by themselves without being tagged to the original procedure someway. It's just: I'm going to submit a claims form with seven non-billable claims on it and nothing else. It makes no billing sense.

Kathy Bryant: Dr. Glasser, so I'm hoping you can help me a little bit. You mentioned for a particular service you might have some 18 different codes, you expected you would have to submit for one visit, could you walk me though that example again.

David Glasser: David Glasser, American Academy of Ophthalmology. So that was for one global period for that. So if you have 179 minutes, 9 typical post-op visits, some are going to be more than 15 minutes. You're likely to have 12 or 15 G-Codes for that global period.

Kathy Bryant: So you're counting if 1 visit was 30 minutes, you're counting it as 3 codes rather than 1 code 3 times?

David Glasser: Correct.

Steve Phurrough: I have one question and this is to the AMA representatives. Dr. Hitzeman talked about the percentages of level two and three codes, E/M codes as post-op visits being in the high 80s and the inpatients being similar being the lower code. Is your data such that you can see how that has changed over the last ten, fifteen years?

Sherry Smith: Sherry Smith, AMA staff to the RUC. We have done that analysis periodically as this issue has been discussed over the last few years and it is trending toward the lower level, so it has been the miss-valued code project and a lot more attention by the RUC to the level of visits. It has trended to the lower levels, but that is something that we could provide with our written comments to specifically address your question. And the point of providing that information to the agency is not to say there isn't any variability with certain surgical services. I believe some surgeries require critical care as part of the bundle. The main point of that—and it's really arguing back at Congress who really did require you to collect level—the RUC is trying to say, this isn't your issue. We understand that the agency is trying to validate and there may be a need to validate the number of visits provided in the global period. Are they actually occurring? But we would contend that there is really no issue there with the level because the RUC has already been very conservative in articulating the level of services within each global. That is why our recommendation is that you do not attempt to collect levels though the claims process. It is not a huge issue and it would be better validated though recognizing that you have to because Congress has included it in the data collection requirements. The RUC would recommend that the information is better accumulated from the larger RAND survey.

Kathy Bryant: So Katie, I had a couple of questions about the survey which you can answer now or in the formal comments. So in the survey, how did the people who were getting the survey, how did they learn about the G-Codes and what information was given to them about the G-Codes?

Katie Orrico: We had a basic introductory paragraph that wasn't very extensive that just informed those who were taking the survey that CMS had proposed to start a data collection process for 10- and 90-day global services potentially using a new G-Code system and any question that referred directly back to the G-Codes in that question there was a table, a chart that had the G-Codes out that was published in the Federal Register was imbedded in the survey so they had the opportunity to refer to that before they answered the questions.

Kathy Bryant: I assume you'll be submitting it with your written comment…

Katie Orrico: Yes, as an appendix. This was just a quick illustration and each individual specialty may or may not highlight their own segregated data that reflects their own individual specialty. We'll also have the full response as part of our comments.

Kathy Bryant: That will be very helpful. Did you ask them, did you have a sense of how these numbers would be different if they were to be required to report the 99024 rather than the G-Codes?

Katie Orrico: We did not survey that question, so I would not even be able to speculate on that point. Our survey wasn't geared towards that.

Steve Phurrough: I had a question. I think Dr. Barney brought up a point I wasn't clear about and I wanted to make sure we understood the hospital EHR [comment]. I think the concern was about making sure hospitals were prepared to bill the code and I wanted to make sure I understood.

Linda Barney: So for data capture, post-operative visits in the office, you can register those with the 99024 submitted on that day of the visit in the office. In the hospital you don't submit those visits anywhere, and you would have to have the hospital EHR be able to capture that visit because that's where the documentation of the visit would be in the patient's chart. You don't carry those visits over to your hospital record in order to report.

Steve Phurrough: Got it.

Kathy Bryant: How is that? I'm trying to think through all that. How is that different than other professional services that are provided in a hospital that you do submit a bill from your practice to Medicare? Why won't the same process work?

Linda Barney: If 99024 was a billable charge, you would be able to take that code back and submit it as part of your bill. It's not a billable charge; it's just recording an encounter in this process of data collection. So as I said before you wouldn't carry this number of visits back and submit it at some time in the care of patient X. I provided these three visits submitted aside from when you did your primary

service because it's all included in the global now so you don't, you aren't registering that number of visits on your claim.

Kathy Bryant: I understand now. I was thinking it would become a billable service, just one without a payment if you were required to report it. I know a lot of people do now report it.

Linda Barney: And you do record. Those who do capture it in their outpatient EHR do. You do your note and you do your visit and you close out your chart by putting the 99024 on it, which allows you to close the chart, but that is not a process that happens in the inpatient EHR.

Steve Phurrough: It might be helpful to educate me on, say, you were billing outside the global period of hospital E/M for hospital inpatient, that code would be?

Linda Barney: That code would be . . . .

Steve Phurrough: That would be part of the hospital EHR?

Linda Barney: Documentation for it would be in the hospital EHR, but you would have a billable service to give to your coder and biller to place on a claim.

Steve Phurrough: Right, okay. A number of you mentioned that in using 99024 there were a number of organizations that require it already, that physicians were used to using on a large scale. So if it's not a billable code, how do their systems manage to accept that code? How do systems where doctors are usually billing those codes operate? Those who have systems where it doesn't work, how does it operate differently?

Dan Siegel: I know in our practice, we use it as a way to close out a note to something in the global period, but the staff [members] don't send that when they see that that claim is just internally processed. It's a check and balance. In the old days it paid for super bill even though it was in the global you might just circle the word post-op. You have indeed ceded this is the official bill but there has been something internal that isn't sent out. If you sent it out the company would simply bounce back the claim saying it's not a payable service.

Steve Phurrough: So when people are relating that large clinics are using this particular code, they're not billing their payers, they're using it all internally.

Dan Siegel: That is correct. It's for internal use and order purposes that the patient checked in and the patient checked out, that the doctor did the documentation and you closed that entity, that loop, but there's nothing that goes out to the external world on that.

Cherie McNett (American Academy of Ophthalmology): I wanted to clarify that point that came up in an earlier question as well. It's not that the use of the reporting of 99024 wouldn't also create an administrative burden in terms of billing and reporting and these clearinghouse rejections and so forth,

it's just that on the front end, in terms of the administrative burden to the physician and how it might affect the practice flow, we know now that they're already in the habit of having to use the 99024 in Epic and other systems just to close out the account, so that data's sitting there. Nothing happens to it external to the internal practice so there would still be some sort of burden in IT requirements or something. We're not saying that 99024 is just flipping a switch and that's an easy thing, but it will at least alleviate the burden on the front end.

Steve Phurrough: Thank you very much for your attendance, your presentations, and your response to questions. This ends the morning session. We'll reconvene in this room at 1:00 for the remote session. We invite you to attend again to listen to those comments, but we'll not be taking comments from those in the room at that time.

Transcript of Virtual Session
CMS Headquarters
8/25/2016, 1:00 to 2:30 p.m. EDT

Steve Phurrough: Good Afternoon. This is Steve Phurrough, I'm a medical officer in the Hospital and Ambulatory Policy Group here at CMS. Let me welcome back those who were present at the morning session and those who are new to the afternoon session. This is the town hall meeting to give stakeholders the opportunity to provide feedback on the CMS proposal for collecting data on global services from our 2017 Physician Fee Schedule Proposed Rule. We have proposed a three-pronged strategy: Claims based data collecting, survey a sample of physicians, and direct observation of such services. Let me introduce the other CMS personnel who are here in the room today. We have Kathy Bryant who is a Senior Technical Advisor in Hospital and Ambulatory Policy Group, Tourette Jackson who is an analyst in the Division of Practitioner Services in the Hospital and Ambulatory Policy Group. We have Patti Truant Anderson from NORC who's assisting us in putting on this town hall and we have Barbara Wynn and Lee Hilborne with RAND, who is our contractor for this data collection project.

This morning we heard from people present in the building. This afternoon we are hearing from those who are remotely signed in. We have 17 people who are signed up to be speakers. Because of the number you will have four minutes to speak. Please be concise, and because you can't see a sign that we hold up to say you have a short period of time left, I will just speak up when you have exceeded your four minutes. That may also encourage all those who are present and those who are remote also to make sure they provide a written comment to the proposed rule. A comment period ends on September the 6th and I'd just like to make sure you understand that your comments that you're providing today are not formal comments. So we'll need those comments in writing to be provided through the typical manner.

Our first speaker will be the American Academy of Orthopedic Surgeons, Robert Blasier. Are you on the line Robert Blasier? [Pause]

Alright our next speaker is the American Academy of Otolaryngology-Head and Neck Surgery, Jane

Dillon. Jane are you on the line?

Robert Blasier: Are you able to hear me? This is Robert Blasier.

Steve Phurrough: Yes, okay, we can now hear you, Robert. All of the others who are on the line, please keep your phones on mute for the speakers. You'll have to take your phone off mute, the operator cannot do that, so take your phone off mute when you're ready to speak. So, Robert Blasier, you can proceed.

Robert Blasier: Yes, you can hear me, right?

Steve Phurrough: Yes, we can hear you.

Robert Blasier: Okay, CMS is required to collect data on global surgical services including the number and level of visits and other items and services furnished during the global period. So, CMS proposes to require recording by any practitioner furnishing global services using the G-Codes to report on time and complexity of post-op visits. While this seems like a noble goal, it would amount to a significant administrative burden. This was more or less an unfunded mandate, which would act to disenfranchise participating physicians, already anxious about MACRA's requirements, MIPS, APMs, and a fundamental shift away from fee-for-service. It's just a difficult time to ask physicians to do this recording because recording time in these increments will be extremely difficult. The work required in submitting all of these G-Codes would be considerable and the likelihood of full compliance by all physicians is low. The data collected by these new G-Codes will be different in character from existing E/M codes in the surgical global, so it would be difficult to draw comparisons between them. It would be like drawing comparisons between apples and oranges and make it difficult to see how, or if, practice patterns have changed since the inception of these codes.

There was talk in the proposed rule of expanding the use of CPT code 99024 which already exists and is familiar to many participating physicians. It's already tracked in some EHR systems and by some large physician group practices. It could be used without the ten-minute increment burden associated with the new G-Codes. Use of 99024 would also allow collection of data on the number of visits and the level of visit could be collected by a survey process. If a practitioner survey is necessary to determine the number and level of post-op visits, it doesn't seem practical to survey all 4,200 plus CPT codes- only a small fraction performed with any frequency might be more appropriate for a targeted survey. The AMA is recommending that rather than surveying all codes, why not just survey high volume, high dollar codes performed by a large number of physicians? This would greatly reduce the administrative burden and [with] the data collected the results could be extrapolated to low volumes codes for which it would be relatively difficult to get meaningful survey data. This seems like a fairly reasonable solution. In summary, we believe that CMS can accomplish all of its MACRA-related mandates and collect meaningful data on resource use in the global period without creating major burdens for physicians and practices. The G-Code approach from the proposal is far too burdensome given that it includes all providers and all global services. A limited approach using surveys of physicians and practices, looking at

target selection services would yield meaningful and useful data for the agency and stakeholders. CMS could look at more granular resource components though their field observations as proposed in the rule to gain more persuasive information as well as through interviews and surveys of commonly used global services also provided in the rules. Having said that, while it's good that MACRA has required CMS to collected data that values surgical services, it's not clear what CMS intended with the data and CMS should have made that clear to stakeholders. This concludes my presentation, thank you.

Steve Phurrough: Thank you, Dr. Blasier. Our next comments are from the American Academy of Otolaryngology-Head and Neck Surgery, Jane Dillon. Would you please take your phone off of mute and you may proceed.

Jane Dillon: I think that Dr. Blasier has summed up some very relevant points, which were also points that I intended to expand upon and I agree with everything that he said. And in addition, I think that if CMS took the approach as outlined by Dr. Blasier, not only would it be a more streamlined approach, I do feel that CMS would get more accurate data. That's the end of my comments.

Steve Phurrough: Thank you, Ms. Dillon. Our next comments are from the American College of Surgeons, Eric Whitacre.

Eric Whitacre: Hello, thank you very much for the opportunity to present. What I'd like to do is briefly present my personal experience attempting to actually record time for the proposed G-Codes. As just a little background, I need to let you know that I am a full-time solo practice breast surgeon, but I'm in a somewhat unusual practice situation. I do programming and I've written my own EMR, which I'm constantly tweaking, so this was just an informatics challenge, but I also have a very luxurious staff. I have six staff members who assist me in the practice so I have a specialty practice with minimal in-hospital post-op care. And it seemed like a good opportunity to test this. Now I may have over-interpreted the information when I designed my software. I thought we would ultimately have to report both physician and clinical staff work, so I designed a popup window that just sat on top of the procedure when seeing a patient post-op. I coded Mrs. Smith or Mrs. Jones had the procedure and it automatically entered the time and the date and the user and I simply had to click on one button to record the time and then, from a drop-down window, I could select the actual work that was performed. But I'll have to tell you, after three weeks, despite my best attempts, I can't make this work and I'd like to explain briefly why.

First, it's actually just not a part of routine workflow. In three weeks we still probably forget to do it probably twenty to thirty percent of the time. That's true for the staff [members] who are recording information on post-op phone calls but also true for myself. Things sometimes get busy in the office and yesterday, despite preparing for this presentation, I forgot to record the G-Codes on three post-op patients. So there's going to be really gross underreporting in the early phases. Another problem is there really needs to be better definitions about what needs to be reported. I had some confusion about whether it was clinical staff that is not MA/PA, but sometimes people were handling phone calls from patients who called in. But, even with physician work, I had some issues understanding, really, what the

post-op work was. For example, when I designed the module, I simply got up from my desk and hit the timer, went to see the patient, got back to my desk, hit the timer. But, it's my staff who actually pointed out to me that I spend a considerable amount of time reviewing the chart, the pathology, outside consult notes before I go into the room. I don't go into the room with a chart, so even trying to do it I was underreporting my own work. And that's obviously going to be different from practice to practice and will need to be better outlined. Another obstacle, and this has been pointed out by other members this morning, was that it's just not a part of work flow. We just don't just go in a room and exit a room. There are phone calls. There are other consults and information that you're processing from other patients.

The biggest obstacle, and this to me was very important, is it actually interferes and detracts from the care of the patient. I need to be spending time processing the pathology, whether or not the patient needs systemic chemotherapy, and so forth. So, it really took away from that as I was focused and I think it will take months before I am able to overcome that. So the question is, how is this really different from billing a 99024 or from standard E/Ms? Well for E/Ms, we have a long history of guidelines and how it's done. And with 99024, I can do that sometimes after the fact if I get busy during the day because the work has been evaluated through the RUC process. So based on this very limited experience, I'd have to strongly recommend that, unless someone comes up with better informatics that I can't solve, this is going to be disruptive, inaccurate, and will detract from patient care. So thank you very much for the opportunity to share with the committee.

Steve Phurrough: Thank you, Dr. Whitacre. Our next comments are from the American Podiatric Medical Association, Tim Tillo.

Tim Tillo: Hi this is Tim Tillo, I'd like to thank CMS for the opportunity to comment. I am representing the American Podiatric Medical Association and over 15,000 practicing podiatrists, the practicing majority of whom are APMA members. I'd like to also look at this proposed rule from a small practice, solo practitioner standpoint. For the past several years we've been barraged with a myriad of reporting requirements and other mandates that require extensive documentation and time. Specifically, I'm referring to things like e-prescribing, PQRS, meaningful use, the audits associated with meaningful use, recovery audit contractors, the conversion to ICD-10, to name a few. To make matters worse, a lack of compliance with some of these initiatives is met with a financial penalty, so I think it's important to note that the standard solo practitioner and practice are already overextended in terms of billing, coding, and reporting requirements. We don't have the luxury of an IT department or the ability to delegate to another department. Each new CMS requirement adds another layer of responsibility to the doctor and the staff, which ultimately affects the operational efficiency of the practice and that has a direct negative effect on the quality of care that is delivered.

So, I look at the proposed rule of the G-Codes as another in a long line of CMS requirements that negatively impacts the small practice with subsequent detrimental effects on the delivery of health care. Specifically we're looking at eight new codes to report for post-op visits and we have what appears to be less than two months to accomplish these four things: First, we have to learn the definition of proper

use of these codes. Second, we have to educate our staff. Third, we have to ensure our software vendors are prepared. And forth, we have to verify our billing platforms are up to speed. So in essence, CMS is adding another reporting requirement for eight new, non-reimbursable G-Codes. And I pointed out these are non-reimbursable because when the average physician stratifies the importance of reporting and billing requirements, I think it's really plausible and understandable that the new G-Codes will be on the bottom of the list, that is, billing services for things like office visits and procedures are going to be viewed as more important. So, if these new codes are last in terms of importance, the bottom line is the average practitioner might have a more lackadaisical approach to actively report these new G-Codes, given both their complexity and their newness, combined with the fact that they're non-reimbursable. So that brings me to the next point of concern and that is the reliability of the data that will be accumulating. Can we really be assured the accuracy in reporting considering the codes? And I'm not sure that the answer to that is yes. This proposed approach to mandatory reporting by all will produce data that cannot definitively be deemed reliable or accurate. And I agree with Dr. Blasier's comments earlier. It makes much more sense to use, as the RUC suggests, a very targeted approach with a very specific sample size of high volume, high expenditure procedures with a broad base of physician utilization, as this would yield more accurate data and have a less deleterious effect than a requirement mandating participation by all. So I am supporting the comments made by the RUC and their representatives and I agree and urge CMS to consider the small practice, solo practitioner and not add these new G-Codes. I think the effect of this on the already overstrained small practice will be expensive and the burdens will have a negative effect on patient care. Thank you for the opportunity to comment.

Steve Phurrough: Thank you. Next we have the American Society of Transplant Surgeons, Michael Abecassis.

Michael Abecassis: Yeah, hi. I'm pleased to have this opportunity to speak regarding the proposed rule on behalf of the American Society of Transplant Surgeons, a medical specialty society composed of over 1,700 transplant surgeons, physicians, and other professionals dedicated to advancing the art and science of transplant surgery to leadership, advocacy, education, and training. Transplant surgeons share the concerns described by others including The American College of Surgeons and the RUC with respect to this first prong of the CMS proposed data methodology. At my own institution, Northwestern, we have an advanced EHR system in place and yet this would be nearly impossible to have this in place and ready to go in the 128 days between now and January 1st. Therefore, any effort to move forward with implementation and data collection utilizing these codes is extremely likely to yield unusable and underreported results, but only after considerable expenditure, time, and effort by CMS and by the surgical community.

With my limited time today I will focus on just three of many challenges unique to transplant surgeons that this proposal would create. First, transplantation is truly an example of a team endeavor and outcomes depend on the concerted effort of a myriad of surgeons, physicians, and non-physician personnel. While I might personally perform the actual transplant, other surgeons in our practice may care for patients during the inpatient and outpatient including lab reviews, reviews of immunosuppression, and other complex medical problems. And it will be extraordinarily difficult, if not

impossible, to capture accurate data for each surgeon patient encounter. Furthermore, pre- and post-transplant work includes care coordination with many other specialties, including but not limited to nephrology, herpetology, infectious diseases, etc. etc. And this occurs at all times of the day and night, adding another layer of complexity to accurately capturing data. Patient and organ survival is not attributable to any single member of the team and the concerted and seamless integration of these efforts of all team members is critical to achieving the most positive outcome. However, CMS's proposal to collect data based on time based G-Codes measured in ten-minute increments that are reportable only by individual providers is inconsistent with the concept of team-based transplant surgery care. Clinical practices vary substantially regarding team coverage and which surgeon, which member of a team, might provide the services for reportable proposed in-patient G-Codes. In some institutions and practices, pre- and post-surgical inpatient visits may be conducted by the primary surgeon and in other institutions and practices efficiency and quality may dictate that other members of the surgical team perform some of these services. Due to this variability, the use of G-Codes to collect data on the scope and intensity of the services performed by the principal surgeon during the inpatient stay is likely to yield internally inconstant and uninterpretable data.

Second, the designation of routine, complex, and critical visits described in the proposed rule are not particularly useful in the context of transplant surgery as we understand it. A visit that does not go beyond the tasks set forth in Table 10 would be reported as a routine inpatient visit. While an inpatient hospital visit to a post-transplant patient may not go beyond the tasks set forth in the table, the complexity of those tasks is essentially greater than that for similar tasks performed for a patient who has undergone straight-forward elective surgery. The complexity levels for the post-operative inpatient visits simply do not reflect clinical complexity which is more accurately defined in the E&M codes, with which the community is already familiar. The office or other out-patient G-Codes proposed by CMS raise similar issues. Transplant patients sometimes travel substantial distances to receive a transplant and sometimes come from the local area. The surgeon who will provide face-to-face outpatient visits during the post-operative period may vary depending on the patient's circumstances and therefore, it is unlikely that CMS will obtain reliable and consistent data on the frequency and intensity of post-discharge, post-operative visits using claims based data. In addition—

Steve Phurrough: Thank you Dr. Abecassis. Our next comments are from the American Urological Association, Jonathan Rubenstein.

Jonathan Rubenstein: Hi, I'm Jonathan Rubenstein, I'm representing the AUA. I want to go straight to our comments. The AUA strongly opposes this proposal, at least in its current form, for a number of reasons: Number one: G-Codes do not represent or accurately capture the level of service provided by provider. There's poor definitions of what's typical, what's complex, and what's critical. The definitions are not clear and based solely upon time. Physicians should not be incentivized to focus on their stop watches, but need to focus on patient care. Number two: G-Codes do not align with clinical workflow. Tracking the entire time a patient is being seen not only is onerous, but as said before, will likely lead to significant underreporting and inaccuracy. Three: G-Codes completely lack validation. Physicians are used to reporting existing E/M services and G-Codes are not comparable in any way to the existing E/M

services that are soon to be bundled into the current global package. Number four: the need to report potentially multiple G-Codes on one day over an entire global period puts an undue burden on physicians and their practices. And on a side note, I know some people are solo practices. I have a large group of 50 doctors in my group and I couldn't imagine the coordination that would need to be done to try to get these codes in accurately. Number five: CMS has not provided additional funding to comply with the proposed data collection but rather puts a proposed penalty for people who do not participate appropriately. Number six: this does not in any way align with the congressional request for a representative sample.

If data needs to be collected, the AUA does propose that a representative subset of CPT codes be chosen based upon defined criteria. Number two: a selective sample of providers should be identified and included in different geographical settings, practice sites, practice size, and specialties collected data on these codes. And three: there should be support or funding from CMS at the study sites to help offset the substantial cost incurred by these practices. For accurate data collection there was suggestion of using CPT codes and CMS felt the current E/M codes might not really capture the greater complexity in the post-operative visit and 99024 can be used, as it's normally included in the surgical package, but putting a modifier on that to go to the same G-Codes may also put an undue burden. The AUA would support using 99024, but again, it might not accurately capture the data that's provided. The AUA supports a follow-up survey for the level of services during the post-operative period as conducted by RAND to collect first-hand accounts for the work that goes into the surgical global and for a subset of CPT codes. Another possibility might be using existing E/M codes for both in-patient, out-patient, and discharge, with the special modifier to show the exact level of services being provided. The AUA recommends this proposal in the 2017 Medicare Physician Fee Schedule be postponed until there is careful consideration given to the methodology and administrative burden of the data collection during the global period. We recognize the need to collect the data. It should be performed in a way that matches with CMS's longstanding intent to reduce the paperwork and regulatory burden on practitioners, especially when the regulation may direct care away from actual patient care. The proposed rule recommendation should adhere to the intent of the directive of the data collection requested in MACRA on the level and number of visits performed during the post-operative period of a surgical procedure. Thank you very much.

Steve: Thank you, Dr. Rubenstein. Our next comments are from the Congress of Neurological Surgeons, John Ratliff.

John Ratliff: Hello, this is John Ratliff representing the Congress of Neurological Surgeons. I appreciate the opportunity to present today. I'll try to hopefully be a little bit shorter than my allotted four minutes. I want to echo a lot that's been said before and I would echo our strong support for what Dr. Blasier has stated before, representing the RUC. I want to give a brief synopsis of a course I taught over the weekend for the American Association of Neurological Surgeons with regards to coding education for neurosurgeons. We do courses; usually teach about 500 practice managers, neurosurgeons, coders from hospitals and from practices throughout the country. We do about five courses a year, teach about 500 individuals. Over last weekend's course we reviewed ICD-10 and we noted to practices how

important correct coding with ICD-10 was going to be and very soon, presumably October the first, we would see denials based on incorrect ICD-10 coding. We spent about half a day going over ICD-10 and getting practices up-to-date with regards to this. Then we reviewed some of the new codes that would be coming in the 2017 CPT manual and how some spine codes would have to be changed. We then proceeded to go through the MIPS system and how the individual portion of quality reporting had been, in our opinion, at least, substantially improved though the MIPS process. The PQRS reporting would now be feasible for neurosurgeons. The EHR and meaningful use systems had been improved substantially, and that there was a new continuous practice improvement category for MIPS with new coding requirements. And that there would be a new system for quality reporting that would be required for practicing neurosurgeons.

While we appreciate a lot of the positive changes in MIPS, there are a lot of changes in reporting that is required and new methodologies that would have to be incorporated into physician practices. After we went all though all that we went over advanced APMs. Now we looked over the different APMs that would be coming up in American College of Surgeons and decide if they want to participate in those or participate in MIPS. And we went through that, we started talking about the possible new G-Codes that would require a complete overhaul of reporting of physician work in the post-operative period. We generally teach to not code to time, but to use approved CPT definitions for E&M work. For the G-Codes we had to note that, okay, forget that, now you're going to have to code for time in ten-minute increments based on all of your interactions with patients in the post-operative setting during office hours, outside of office hours, etc. It is an entirely new reporting mandate and an entirely new reporting burden that's going to generate a lot of excess work for physicians and staff members. And by the time I got through all of that and told them we would start all of this on January 1st, 2017, I fully [expected] the physicians to be throwing chairs at me and rising up in riot, simply because implementing all of this with this close a deadline is going to be well-near impossible.

And as noted by many other practitioners and many other commenters on this call, I think the result of that is going to be very poor data collected though the G-Code system and that there will be so many other drains on physicians' resources and on staff time complying with this system will be difficult, and hence the data generated by this system is going to be deeply flawed. I just don't think it's going to be useful. As Dr. Blasier noted, there are other alternatives available to CMS; there are other sampling methodologies that could be used and I think CMS will, at the end of the day, have a much more robust understanding of work taking place in the global period by adopting a different approach. Again, I appreciate the opportunity to present and thank you.

Steve Phurrough: Thank you, Dr. Ratliff. Next we hear from the CPT Editorial Panel, George Williams.

George Williams: Thank you, Dr. Phurrough. I'm George Williams representing the CPT Panel and I am chair of the RUC surgical global work group. The surgical global work group has been following the issue of the surgical global since the agency's initial proposal to remove surgical globals in the 2015 proposed rule. Given the extended period of time the work group along with the RUC has spent analyzing this issue, many physician stakeholders have had input into the specific recommendations that would

benefit both the collection of data and the work done in the surgical global period and places as little burden as possible on physicians and their staff who report this information. We believe the RUC is a uniquely qualified body to make the following recommendations not only because there are physicians at the table that represent many different specialties across the country and are also keenly aware of the work and practice expense components that go into valuing surgical services.

The RUC therefore has the following recommendations: CMS must collect the data from a representative sample. The legislation is clear that a representative sample must be collected to use this data. The CMS proposal to collect data from every physician is simply too burdensome. In addition, it fails to recognize [that] the vast majority of surgical services are low-volume. Finding an appropriate set of high-volume services, the RUC reviewed the 2014 Medicare database and identified a set of criteria which would focus the collection process on a wide range of relatively high-volume surgical procedures which are commonly performed by physicians. The criteria are as follows: Medicare volume of at least 10,000 and/or $10,000,000 in allowed charges and at least 100 separate physicians performing the procedure in 2014. These criteria identify 235 codes primarily performed by a wide range of specialties. The RUC will be submitting this list of codes with the comment letter in the coming weeks. The RUC is recommending that CMS limits its data collection to services within this set of 235 codes. Also in regards to the identification of a representative sample of physicians, CMS should select the sample to include various geographic and practice types. CMS should begin by reviewing the physicians who perform the 235 that are a subset of these higher volume procedures. This narrowing of the data process should alleviate CMS's concerns about how to create a representative sample. These high-volume codes are performed by enough physicians that choosing physicians in various practice settings and locations will not be an issue.

Our second recommendation is that CMS should use CPT code 99024. The RUC has consistently recommended that CMS use 99024 because it is accepted in the large EHR platforms such as Epic for Internal Practices. We've confirmed that several large physician group practices including the Mayo Clinic and Kiesinger use 99024 to track all their post-operative visits. In addition, while 99024 is the preferred method to collect the data, CMS should not mandate that the code be billed in 10-minute increments. As the RUC and many stakeholders have told CMS since this proposal was published, having physicians and their staff monitor time with patients in 10-minute increments is extremely burdensome. Our final recommendation is that CMS should not use claims data to collect the level of visits in the surgical global and should instead use individual surveys. We believe the legislation is clear that none of this information has to be collected though claims. The RUC has, on multiple occasions, given CMS data that the post-operative visits included in the surgical global are tightly clustered around low- and mid-level hospital visits. Nearly 90 percent of office visits are either 99212 or 99213, nearly 87 percent of the post-operative hospital visits are 99231 or 32. CMS has already instructed RAND to conduct a more in-depth survey to collect firsthand accounts of the work that goes into the surgical global. CMS should use these surveys to collect the level of post-op visits on a subset of services within the list of 235 codes. Using this method, CMS will be able to focus their limited resources on high-volume services while increasing the likelihood that meaningful data will be collected. Thank you.

Steve Phurrough: Thank you, Dr. Williams. Our next comment is from the Detroit Medical Center, Folusho Ogunfiditimi.

Folusho Ogunfiditimi: Thank you very much; I'd like to thank CMS for giving us the opportunity to participate in this town hall. My comments will be relatively brief with the unique approach to some of the things which have already been commented on. I agree with my colleagues on some of the statements which have been made so far, but I want to make reference to the RAND document on page 31, the third paragraph, where it states, and I quote, "if both the procedure list and the MPP provided care during a single visit, then the code will be submitted by the physician based on the combined time of the qualified MPP and the physician." We're recommending that—so, what that statement essentially states that CMS is proposing that these codes be defined as a shared visit and while we're stating that that would be inconsistent with current CMS and CPT coding for procedures which are defined as non-shared visits, which ostensibly means that whoever does the bulk of the work is who should be appropriately either reimbursed or compensated based on the specific work that's done. Critical Care services and consults right now are non-shared services, so what we're proposing is that if these codes are defined and based on all the comments that have been made, that they be defined as non-shared services, which would allow CMS to appropriately document those who are actually providing the services and it will enhance the accuracy of the data that's provided and the shared as opposed to having the shared service which could potentially result in masking some of the work that is done by some of the other providers on any specific services. That's all that I have.

Steve Phurrough: Thank you. Our next comments are from Duke University Medical Center, Peter Smith.

Peter Smith: Thank you, Dr. Phurrough. My name is Peter Smith. I'm the chief of cardiothoracic surgery at Duke and a practicing thoracic surgeon. Although I have other roles, I want to stress that I am speaking here only on behalf of Duke Health Systems. Duke is a large academic tertiary care center with 250 surgeons. My comments, and I hope they are not duplicative of what you've listen to all day, will be directed at the adverse impact of the proposal on our health system, its physicians, and, ultimately, its patients. Others have discussed the economic burden and we estimate that the proposed data collection process will require the generation of almost 600,000 additional code filings at Duke at a cost of between $4.6 and $8.3 million. These costs include IT changes, compliance review, coding staff time, and 750 hours of staff time in physician education. This is not including physician time. To assess this we utilize the CMS physician timeline and the underlying time components in the RUC database to develop a crosswalk between the proposed G-Codes and the E/M codes that are allocated in each of the global codes. We were able to initially analyze one of our surgical sections that has 15 physicians who submit 3,300 global codes in each year. The crosswalk indicated that 98,000 new G-Codes would need to be reported annually, which is more than a 30-fold increase in reporting. Estimating a physician time of 5 minutes per G-Code, including documentation, this would require 10 and a half hours per week per physician which is about a 15 percent increase in workload from 65 hours per week, most of which would not replace time in the current workload. We believe that this will significantly detract from the quality of patient care delivery. Utilizing the published annual Medicare utilization data, we estimate that nationwide there will be 316 million new G-Code claims which is almost exactly the number of

independently billed E/M claims for the same codes. At five minutes of physician time per code, that would be 26,000,000 working hours for providers nationwide, which is a staggering number. Our estimates are less than the 450 million estimated by the RUC, probably due to our inability to estimate the use of the two phone and internet G-Codes in the details of the crosswalk we created.

As CMS finalizes its methodology, we recommend that it formally assesses the economic burden that it places [on] providers and health care organizations and consider remedies. We also recommend that CMS, should it finalize the G-Code comprehensive methodology, develop and publish its own crosswalk from CPT codes to G-Codes assuming that its time file is correct. This transparency is important to enable proper education of physicians to estimate the proposed burden and provide details of compliance and its cost. Finally we urge CMS to perform analyses such as provided here to assess the potential for degradation of quality of care provided to Medicare beneficiaries because of this time burden of compliance by physicians. That concludes my remarks and thank you very much.

Steve Phurrough: Thank you, Dr. Smith. Our next comments are from the East Carolina University Brody School of Medicine, Charlotte Price. Charlotte Price, are you on the phone?

Alright then we'll move to our next commenter, MEDNAX, David Kanter. The others, please put your phones on mute.

David Kanter: Thank you, this is David Kanter. I want to thank CMS for this opportunity for outreach on this important subject. MEDNAX is a nationally-based health care solutions partner, includes support for several surgical practices around the country including pediatric surgery and pediatric EMT. Because our practices are pediatric-focused, there tends to be less Medicare focus procedures. It's primarily a Medicaid and commercial payer focused type of surgical practice, but I truly feel the pain of the medical reporting requirements that we heard on the phone today and just wanted to comment on some of those. We realize that data capture is going to be limited to Medicare-centric types of procedures, but the conclusions from those data will have some impact on all procedures including those that focus on a Medicaid population. I especially want to highlight and emphasize comments made by physicians such as Dr. Whitacre and Dr. Smith with regards to the burdensome nature of the proposal that CMS is suggesting, as a pediatric-focused hospitalist and internist, I have concerns about the impact that these regulations will have on surgical physician performance and patient care.

Frankly, as a pediatric-focused hospitalist I would be concerned with the amount of regulatory burden that this is imposing on the surgeons with regard to their ability to focus appropriately on the highly acute and intensive nature of the kinds of patients they're seeing in the pre- and post-operative period. I do understand the need to collect data on these types of procedures. I would agree with the comments that have been made to try to use the 99024 structure that's been well established in the coding world in terms of tracking the kind of visits that CMS would like to generate data on. The 99024 code is very familiar to all sorts of surgeons, both pediatric and adult surgeons, and it is used across all payer domains, not just Medicare, but also Medicaid and even commercial to some extent. With that respect, it does offer the ability to collect data beyond a Medicare centric focused type of procedure inventory. I

realize the 99024 code does not necessarily give all the detailed data that CMS is seeking, but it does give important data and it does span a broader scope of surgical procedures than for instance the G-Code proposal that's being submitted. That concludes my remarks; I appreciate the opportunity to speak today.

Steve Phurrough: Thank you. Our next speaker is from the North American Spine Society, Eric Mayer.

Eric Mayer: Hi, I appreciate the opportunity CMS has given us to comment on this code proposal. I agree with the comments of my colleagues and I'm going to keep it brief and just summarize, I think, in agreement with all the points you have heard. The North American Spine Society is a multispecialty organization, which makes us a little bit different. We represent nearly 8,000 surgical and procedural folks who will be affected by this proposal. First, let me start by saying that NASS fully appreciates and agrees with CMS's goal of insuring that all CPT codes payable under Medicare are appropriately valued using current and accurate data on physician and clinical staff work. We also agree that supplies and equipment input should be appropriately valued and have taken issue with some of the statements that came from the RAND study. The answer to this proposal to supplement data with G-Codes for ten-minute increments is a burden that looks like it far exceeds the statutory data collection requirement under MACRA. The amount of burden for physicians with only a two-month window to teach staff how to re-code to keep track of exactly what happens in these very busy clinics is really an undue burden that seems to be statutory overreach, in our interpretation of what we've seen. The every-ten-minute post-operative requirement would require a physician to almost manually keep track of things—handing this off [to] his staff who would hand off to the billing department—is not easily teachable or achievable with current electronic medical record technology and the burden would be substantial. On the default side, on the counterfactual thought that the majority of physicians who run boutique private practices or work at a large academic center where the electronic medical record or staff hires are not quite as nimble, would be locked out from reporting. You would then lose out on that data and you would be making a choice based on the physicians who are most capable and who had the best ability to hire additional staff to comply with that. Our choices would be based on data that does not meet the MACRA requirement for appropriate polling of physicians involved in this and it would not be a benefit for anyone. The existing code of 99024 as stated previously for post-op follow-up visits is most familiar to physicians and is already used by a great deal by a great many groups and probably would suffice as a compromise. MACRA ignores the fact that 4236 global codes fall in this, but only 259 of this sort of high-volume post-operative codes that would exceed—

Steve Phurrough: Thank you, Dr. Mayer. We appreciate your comments. The next speaker is the Society for Gynecologic Oncology, David Holtz.

David Holtz: Good afternoon, I'm Dr. David Holtz and I'm here today on behalf of the SGO, the Society for Gynecologic Oncology, to share our thoughts regarding this CMS proposed data collection resources used in furnishing global surgical services. I want to thank CMS for holding this town hall. The SGO is a premier medical society for health professions, physicians, physician assistants, nurses, medical oncologists, trained in the comprehensive management of gynecologic cancers. The SGO has over 2,000

members representing the entire gynecologic oncology team in the United States and abroad. The SGO does not support the proposal by CMS to collect data on the 10- and 90-day global period and all procedures from all surgeons using the newly created G-Codes.

A lot of our objections have been already presented by other speakers, but just to summarize, we believe that, the CGO believes and urges CMS to work with small focus groups of surgeons to provide CMS with a representative data sample of the services provided during the global period. By working with small focus groups of surgeons that have volunteered to be part of the effort on behalf of their surgical subspecialty, CMS can insure those collecting the data are well trained in the accuracy and the data can be validated prior to use. Many of our members, myself included, do not have the administrative resources to collect the G-Codes by the methods that CMS has proposed. We would have to pay for electronic health record contractors to create workarounds for the G-Codes; this could be costly and will probably not be done in the two months necessary to completion. There are no funds available for these activities especially the time when practices are already trying to gear up resources to participate in the Merit Incentive Pay System for 2017. Additionally, we would have to provide office staff or scribes to follow around to collect the G-Code data in 10-minute increments, again this is an unfunded administrative activity. We are not even sure that 10 minutes is the right increment, as has been brought up by several other speakers. And the level of specificity regarding the types of visits doesn't seem to correlate unlike the E/M codes we're already used to and already have. By working with a small group of surgeons to collect a representative sample, you could use existing E/M codes for data collection either in existent claims with no charge attached or a contractor could collect the data necessary via a simple check box form using the exiting E/M codes. Another option could be that CMS could work with a sample group that could collect offices and notes and then have the codes assigned to count the work by CMS.

The SGO urges CMS to collect the work in the post-operative period in phone calls, emails, and while we do not support the use of the separate G-Codes to do this, we do appreciate seeing CMS was collecting this specific data. The SGO would like to thank CMS for the opportunity to provide this town hall meeting to express our views. We urge CMS to adopt a policy that collects the data from the representative sample that is least burdensome and least costly for surgeons in general and utilizes a select group of volunteer surgeons who are better trained to provide an adequate sample for statistically-viable, accurate results. Thank you very much.

Steve Phurrough: Thank you, Dr. Holtz. Our next comment is from the Society of Thoracic Surgeons, Francis Nichols.

Francis Nichols: Thank you for the opportunity to come. I am a thoracic surgeon speaking on behalf of the Society of Thoracic Surgeons, representing more than 7,000 cardiothoracic surgeons, researchers, and allied health care professionals. I'm sorry if I'm repetitive but these points are worth making. STS is disappointed with CMS's proposal to mandatorily require collection of claims-based data submissions from all surgeons on all pre- and post-operative visits and resources used in furnishing global services. Mandatorily requiring this reporting by all providers of global services goes way beyond the

representative sampling called for in MACRA. Furthermore, the complexity of CMS's proposal places undue time constraints on physicians and markedly increases administrative and financial burden on physicians and their practices. Physician and practice resources committed to fulfilling this uncompensated, mandatory, exhaustive reporting will likely be diverted from patient care and have a deleterious effect. Congress saw CMS's original proposal to eliminate surgical globals in 2015 as harmful to patients and legislation instructed CMS to preserve global surgical packages. Congress, however, did permit a less destructive mechanism allowing the agency to study global services by collecting data from a representative sample of surgeons. In the proposed rule, CMS has gone far beyond representative sampling, and instead proposed not one but three diverse ways of implementing their misinterpretation of congressional intent.

STS believes CMS's proposal to collect global surgical data from all surgeons using never tested G-Codes will not paint the clear picture of care provided during the global period as that care is greater than the sum of the parts defined in the proposed rule. The G-Codes fail to capture code coordination between surgeons and residents and MPPAs, pathologists, nurses, and other providers all representing important aspects of surgeon work. Educating our membership and implementing these complex G-Codes by January 1, 2017 is an impossible task with a totally unrealistic timeline. Successful implementation goes far beyond the education of providers but as you've heard, includes putting systems and processes in place to capture these codes and submit them on claims. As surgical care may take place over a 10-day or 90-day time frame, multiple additional claims will be submitted. I use a patient I saw just this morning, [an] esophageal gastrectomy patient, I will now have to personally submit 17 additional claims to capture that work and submit the codes. Extrapolate that across all physicians and all global codes and you get the extraordinary numbers that Dr. Smith mentioned. An alternative would be for me to submit all claims for the 90-day global surgical procedure after 90 days. Doing this however would dramatically affect the physicians' days' revenue outstanding and have a negative downstream impact on Medicare beneficiaries and secondary coverage providers. I think it is unrealistic to ask providers to wait greater than 90 days to submit a claim for services provided three months earlier. You've heard both small practices and large health systems will struggle putting in the necessary infrastructure in place to capture and report this data. Survey data from the surgical coalition substantiates the substantial financial impact this will place on physicians.

Given the magnitude of what CMS is proposing, the incremental cost for physicians and practices should not be unfunded. CMS should consider some form of payment for providers who will now have to commit resources to generating huge numbers of additional claims if they persist in this endeavor. Surgical workload is not conducive to the ten-minute proposed structure. We believe a physician's time and resources are best spent caring for patients rather than accounting for our work in ten-minute increments. This new administrative burden will be overwhelming especially when surgeons are getting used to reporting requirements under MACRA. It is not clear how this reporting fits into other CMS programs including the mandatory bundle payments for coronary artery bypass grafting. G-Codes fail to capture the work performed by residents under the teacher position rule or mid-level providers employed by practices. Finally, physician burnout is a real and increasingly reported event. The agency's proposed G-Codes are yet another example of an administrative load placed on providers' shoulders

with no demonstrable benefit to patients. In conclusion SPS is disappointed [that] CMS has yet again proposed an extremely burdensome initiative to ameliorate a perceived problem specifically in regards to issuing the collection of data used in furnishing global services. The agency should start with a limited scope collection process utilizing a representative sample to better understand the necessary post-op visits and other elements furnished in the global surgical period. That's what was called for in legislation. Thank you very much.

Steve Phurrough: Thank you, Dr. Nichols. Our next comment is from the University of Wisconsin Medical Foundation.

Amy Leipert: Thank you to CMS for the opportunity to present comments today. My name is Amy Leipert, I'm a trauma and acute care surgeon speaking on behalf of the University of Wisconsin Medical Foundation. We are an academic intuition with over 1200 physicians. We would like to express our position against the proposed CMS policy to collect data on all 10- and 90-day day global series from all physicians who utilize them. The proposal of the eight G-Codes [is] also not supported for many reasons stated as previous. I would like to take a moment to support the comments made by Drs. Whitacre, Blasier, Rubenstein, and Nichols, among many others who have spoken today.

The comments that I've prepared include: Surgical care is complex and is infrequently delivered in tidy ten-minute defined intervals of care. Additionally, surgical patient care times are necessarily compressed due to care delivery limitations such as OR schedule demands, in-patient rounding, and other unanticipated and emergent activities. Any additional unnecessary distraction from the surgeon-patient interaction such as excessive and unnecessary administrative documentation such as this proposed plan only further limits and degrades the patient interaction experience. From a hospital administrative perspective it is highly unlikely that systems for reporting a whole new coding system in the electronic health record as well as the staffing needs to process this massive amount of data will be in place by January 1, 2017. This will also contribute to new administrative costs, both in staff necessary to process these claims as well as in data management. Physicians are going to struggle to define and document patient care encounters to incorporate complexity and medical decision making. They will also [be] burdened with yet another administrative and bureaucratic task that adds nothing to the period of post-operative patient care. This is a time that patients often have extensive follow-up questions regarding the results of operative interventions as well as their recovery. As a trauma surgeon and emergency general surgeon, I frequently spend extensive time post-operatively both in the hospital but especially in the clinic in order to explain to patients and their families and loved ones the often complex emergent surgical problem they face as well as council them though the expected recovery, possibility of unanticipated complications, and other questions that they have. It will be nearly impossible to capture this necessary component of care with the currently proposed G-Codes and will administratively take time away from the patient's bedside and clinic appointment.

At this time we propose that CMS delay the currently planned full implementation of coding for January 1, and instead consider a representative sample data collection as directed by congress via MACRA. If the choice by CMS is to move forward, we encourage you to narrow the scope of codes to Medicare

volume of at least 10,000 and/or $10 million in allowed charges and to ensure that at least 100 separate physicians perform the procedure as of 2014. Number two: uphold Congress's directive to sample only a select and representative sample of physicians. Number three: utilize the 99024 code to evaluate the number of post-op visits as presented multiple times here today. Or, number four: develop a follow-up survey to additionally understand the work that surgeons provide within the global fee. Thank you for your time and consideration in amending this proposed policy.

Steve Phurrough: Let's return to the East Carolina University Brody School of Medicine, Charlotte Price, are you on the phone? [Pause] I guess not. That concludes our list of presenters. Thank you very much to those who took the time to call in and provide us with your comments, and we once again encourage you to provide your comments in written format in the formal comment period that ends on September the 6th. Instructions are in our proposed rule. I believe that concludes our town hall meeting, thank you