October 28, 2021

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

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

Dear Mr. Tee,

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

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

Recap of Specialty Society Discussion Points

<u>AMA RUC Review of 10- and 90-day Global Codes</u>

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

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

Past Precedent for Retroactively Adjusting Global Code Values

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

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

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

Ophthalmology Examples

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

[1] Medicare: Physician Fee Schedule for Calendar Year 1998; Payment Policies and Relative Value Unit Adjustments and Clinical Psychologist Fee Schedule, 42 C.F.R. § 400 (1998).
[2] Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology, 71 Fed. Reg. 37218 (June 29, 2006).

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

- To highlight the inequity and illogic of this policy, consider the review of CPT codes 67141 and 67145 (*treatment of retinal breaks using cryo or laser to prevent retinal detachment*). The RUC recommended, and CMS accepted, work values of 2.53 RVUs for these codes, including two level-3 post-operative office visits in a 10-day global period. The 2022 physician work value of the two post-operative office visits alone would be 2.60 RVUs, greater than the work value of the procedure plus the post-operative office visits. This clearly demonstrates how a policy that does not apply incremental E/M increases to global codes disrupts relativity.

- Further, the societies considered valuing CPT codes 67141 and 67145 as 0-day global codes and billing post-operative visits separately when performed. However, both visits are necessary and typical within 10 days, making these codes a good fit for a global period and in harmony with other similar eye procedures. In addition, a 0-day global code would burden patients with additional out-of-pocket costs, requiring co-pays for both the procedure and each of the post-operative visits.

Background on the Valuation and Coding of the Global Package

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

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

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

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

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

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

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

Questions from CMS

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

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

   Response

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

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

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

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

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

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

Response

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

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

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

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

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

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

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

Sincerely,

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