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September 2, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1654-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

SUBJECT: CMS-1654-P Medicare Program; Payment Policies Under the Medicare Physician Fee Schedule (PFS) and Other Revisions to Part B for CY 2017; Data Collection for Global Surgical Services

Dear Mr. Slavitt:

On behalf of the 4,000 practicing neurosurgeons in the United States, the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed 10- and 90-day global surgery package data collection plan. We have submitted comments related to other payment and quality issues addressed in the proposed Medicare Physician Fee Schedule rule in a separate letter.

EXECUTIVE SUMMARY

Summary

- The AANS and CNS are extremely disappointed that CMS has proposed a policy to collect data on **all** 10- and 90-day global services from **all** physicians who perform these services. The proposal is contrary to both the letter and intent of the Medicare Access and CHIP Reauthorization Act (MACRA), which directed CMS to gather data from a "representative sample of physicians" before making any changes to the global surgery package.

- We strongly oppose the claims-based approach (prong one of a three-prong strategy for collecting global surgery information) to data collection and the use of eight new and untested G-codes for reporting global surgery data. The claims-based data collection mandate is so burdensome that most physicians will not be able to comply by January 1, 2017, which will result in CMS being unable to collect accurate and usable data, particularly in light of the unfinished final rule at the time of this writing.

- The AANS and CNS urge CMS to approach this project in a step-wise fashion. Initially, the agency should proceed with prong two (a survey of representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified period) and prong three (a survey to collect primary data on the activities and resources involved in delivering services in and around surgical events in accountable care organizations) of the proposed data collection plan. This will allow CMS to meet its statutory

obligations to initiate a data collection process by January 1, 2017, with a representative sample of physicians.

- If CMS intends to move forward with claims-based data collection, we urge the agency to use the existing CPT code 99024, "Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure."

- Should the agency need additional time to work out the details, the AANS and CNS fully support a decision by CMS to initiate a "process" on January 1, 2017, to further develop — in collaboration with the specialty societies, the American Medical Association and the AMA/Specialty Society Relative Value Scale Update Committee (RUC) — a global surgery data collection plan that will obtain adequate information in the least burdensome and disruptive manner.

- The AANS and CNS likewise object to the G-code method for collecting global surgery data in teaching hospital settings. If CMS includes academic medical practices in their representative sample, the agency would be able to obtain information on the services provided by residents under the direct supervision of attending surgeons in the prong two survey. Therefore, a "special" rule for physicians at teaching hospitals is completely unnecessary.

- The AANS and CNS appreciate that CMS is not proposing to impose the 5 percent payment withhold at this time, and we fully support this decision.

CMS should not implement the proposal to collect claims data via G-codes

- **Burden**. The proposed time-based G-codes are not aligned with clinical workflow. The burden associated with physicians attempting to track their time in 10-minute increments is onerous and will result in underreporting of data. According to a surgical community survey, neurosurgeons will face significant challenges integrating the proposed new G-codes and data collection processes into their practices. In an attempt to comply, most neurosurgeons will have to make major changes to their practice operations. Nearly 40 percent of respondents anticipate it will cost them between $25,000 to $100,000, and another 30 percent estimate they will spend more than $100,000 on compliance

- **Typical**. CMS' definition of a "typical" visit requiring the reporting of GXXX1 or GXXX5 does not incorporate complexity or medical decision making. Any visit that includes an activity listed in Table 10 of the proposed rule is considered "typical;" however, the work (i.e. time and intensity) associated with these activities can be drastically different.

- **G-codes lack validation and comparability with existing E&Ms**: The proposed G-codes should not be used because they have not been validated or tested. They also are not comparable with existing E&M services assumed to be bundled into the current global package.

CMS should collect data from a representative sample

- Again, MACRA's language clearly states that CMS should collect data from a "representative sample of physicians," **not** from all physicians.

- It is not necessary for CMS to begin by collecting data on all 4000+ 10- and 90-day global codes. At the very least, low-volume codes should not be included.

If CMS plans to move forward with claims-based data collection, the agency should:

- **Select a representative sample of physicians**. CMS should identify a representative sample of physicians to include various geographic settings, practice types, practices sizes, and specialties for data collection.

- **99024 for number of visits**. The representative sample would be required to report one 90024 code for each visit to capture the number of post-operative visits provided.

- **Follow-up surveys for level of visits**. The AANS and CNS believe that it is not necessary to distinguish the level of service in a claims collection process at all, as there is no identified problem to solve regarding the level of E&M bundled into the global surgical period. If necessary, however, CMS should instruct RAND to conduct more in-depth follow-up surveys to collect firsthand accounts of the work that goes into the surgical global for a subset of CPT codes.

COMMENTS

Overview of the Global Surgery Data Collection Proposal

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

1) Prong One: A "comprehensive claims-based reporting about the number and level of pre- and postoperative visits furnished for 10- and 90-day global services." This will require all surgeons filing claims for 10- and 90-day global surgery services to report on the type and level of all visits included in the global period using a new G-codes system starting on Jan. 1, 2017.

2) Prong Two: A survey of a large, representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time, such as two weeks; and

3) Prong Three: A survey to collect primary data on the activities and resources involved in delivering services in and around surgical events in accountable care organizations. A small number of ACOs (Pioneer and Next Generation ACOs) will be surveyed.

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

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

Improving the Valuation of the Global Surgical Package

The AANS and CNS strongly supported section 523 of MACRA, which prevented CMS from eliminating the 10- and 90-day global periods (although we did not support the section granting CMS the authority to withhold 5 percent of physicians' reimbursement to ensure compliance with this provision). We continue to believe that the goal of ensuring that global surgery services are accurately valued can be achieved

without completely overhauling the existing coding structure. To do otherwise would lead to an administratively burdensome disaggregated system, that would result in fragmented patient care and is completely contrary to current trends toward bundling. Thus, we are committed to working with CMS to gather data on the 10- and 90-day global surgical package — in the least administratively burdensome manner — that will achieve the goal of accurately valuing these services.

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

We are deeply discouraged by both the process and the results of the RAND report on the use of G-codes. Specifically, we are disappointed that a neurosurgeon was not included on the RAND technical panel. As a specialty that primarily provides surgical services reimbursed under the global surgical package, we believe this was a glaring and an unfortunate omission. Beyond who was invited to participate on the technical panel, the AANS and CNS believe the agency's proposal is contrary to both the letter and intent of the Medicare Access and CHIP Reauthorization Act (MACRA), which directed CMS to gather data from a "representative sample of physicians" before making any changes to the global surgery package. Furthermore, while MACRA requires that a data collection process is in place by January 1, 2017, the G-code approach is an untested and flawed approach to collecting this information. At the very least, before implementing this data collection method, RAND should have first conducted a valid pilot study with a limited number of physicians and codes. MACRA does not require CMS to launch the definitive study by January 1, 2017. Rather the agency must merely begin the "***process***" for evaluating 10- and 90-day global surgery services. We believe that a more rational approach to conducting this study should be employed, and working collaboratively with the physician community, CMS can meet its MACRA obligations.

G-Code Data Collection Burden

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

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

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

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

G-Code Approach is Internally Flawed

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

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

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

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

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

Surgical Community Survey on Proposed G-Codes

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

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

What do you anticipate will be required to integrate the new global surgery G-codes and data collection processes into your practice?	
Answer Options	**Response %**
Developing new processes for tracking, collecting and distinguishing between pre- and post-operative visit information	84.6%
Modifications to my electronic health record (EHR) and/or billing systems	88.5%
Additional existing staff time to track and process pre- and post-operative visit information into the medical record and billing system	76.7%
Hiring new staff members (billing, scribes, other) to track and process pre- and post-operative visit information into the medical record and billing system	68.1%
Additional physician time spent on tracking pre- and post-operative visit information beyond that which is currently dedicated to documenting medical services	91.8%
Purchase additional software to support and capture pre- and post-operative visits	53.8%
Increased number of claims submitted as well as significant new costs for the additional submission	82.4%

What kind of processes do you anticipate will be required to comply with the new global surgery G-code data collection process?	
Answer Options	**Response %**
Developing new pre- and post-operative visit tracking forms	86.7%
Developing patient engagement and/or pre- and post-operative visit tracking forms	73.7%
Developing a method for transferring pre- and post-operative visit data from one treatment site to another	66.9%
Ability to differentiate Medicare patients in the pre- and post-operative settings so that G-codes are properly applied based on the patient's payer and data aggregated for this subset of patients in the practice	88.8%
Hiring of scribes to shadow clinicians to document services	50.4%
Use of handheld technology to document time spent providing pre- and post-operative services	58.6%

Approximately how much do you anticipate it will cost (including modifications to EHR/billing systems, staff costs, loss of productivity, etc.) to integrate the new global surgery G-codes into your practice in 2017?	
Answer Options	**Response %**
$0 to 10,000	2.2%
$10,001 to $25,000	7.2%
$25,001 to $50,000	13.7%
$50,001 to $75,000	11.5%
$75,001 to $100,000	14.7%
Over $100,000	30.2%
Not sure	26.2%

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

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

- *Continue with current global period approach, since the simple and complex postop patients average out over time.* (Neurosurgeon from a medium-sized private, single specialty practice in the South)

- *Proposals such as this add extra hassle and risk for physicians providing for Medicare patients. The restrictions are so onerous, that it will encourage dishonesty just to complete the forms. People trying to honestly track every 10 minutes of time will quickly burn out. People will see less patients. Doctors with options are already realizing the vast majority of legal risk comes from Medicare/Medicaid patients. I foresee a time when good doctors decide that the risk is not worth the declining reimbursement. This type of soul-crushing intervention will simply encourage physicians to compete for non-government payers, and restrict access (or lose it altogether) for Medicare and Medicaid patients.* (Neurosurgeon from a large hybrid private/academic, multi-specialty practice in the Midwest)

- *Keep payments on a global basis as before because it does not place demand on surgeon's nonclinical/administrative time away from the care of the patient. Why would one debundle episodes of care for surgical treatment, when the trend is to pay for episodic management in healthcare?* (Neurosurgeon from a small hybrid private/academic, single specialty practice in the Midwest)

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

Specific Examples of Neurosurgeon Procedure Vignettes

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

- **Neurosurgical Case Example #1 — Head Trauma**. An unrestrained automobile passenger with a severe closed head injury and an acute subdural hematoma due to an accident presents to the emergency department. The patient has multiple injuries, a Glasgow Coma Scale score of 5T, and is intubated. He is taken to surgery upon admission for a craniotomy to evacuate a subdural hematoma and place an extraventricular drain (EVD) (2 hours). The CPT codes for craniotomy for subdural hematoma evacuation and EVD are submitted. On postoperative day one, the patient is examined off sedation and computed tomography (CT) scans of the head are reviewed (30 minutes of surgeon

time caring for the patient). Another 20 minutes is spent rounding on postoperative day two. That day, the patient's parents arrive, and the surgeon spends one hour with them discussing the severity of the injury, the surgical procedure, and the prognosis. The evening of postoperative day two, the surgeon responds to a series of calls over several hours regarding elevated intracranial pressure and spends 60 minutes reviewing CT scans and calling in orders. On postoperative day three, the intracranial pressure becomes refractory to exhaustive nonoperative measures. The surgeon decides to proceed with a decompressive hemicraniectomy (2 hours). The following day, the cycle of rounding (30 minutes) and family briefing (60 minutes) continues. On postoperative day five, the EVD stops working, and the surgeon replaces it (20 minutes). Over the first week, several hours (dozens of 10-minute intervals) are spent managing this patient. After four weeks in intensive care and two weeks in rehabilitation, the patient returns to the operating room for elective cranioplasty (2 hours). And this does not include any care rendered to the patient within the 90-day global surgery period once he goes home but returns for follow-up visits to check on his recovery status.

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

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

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

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

- **Neurosurgical Case Example #2 — Subarachnoid Hemorrhage w/Vasospasm and Hydrocephalus Requiring Shunt**. A 69 year old woman presents with temporary loss of consciousness and the worst headache of her life. CT of the head shows diffuse subarachnoid hemorrhage, and CT angiogram shows a wide-necked aneurysm of the left internal carotid artery at the origin of the posterior communicating artery. She is admitted to the ICU for stabilization, and the

next day she is taken to the operating room for open surgical clipping of her aneurysm, as well as placement of an external ventricular drain (EVD) on the right to treat hydrocephalus noted on her imaging. On postoperative day one, the patient is examined, a CT scan with CTA is reviewed to ensure adequate treatment of the aneurysm as well as the hydrocephalus. (30 minutes). On postoperative day two, the patient has cerebral salt wasting and electrolyte management issues that require consultation with endocrinology (30 minutes spent rounding and communicating with the consulting teams). On postoperative day three, twenty minutes are spent rounding on the patient, and in the evening the patient develops an episode of speech arrest and right arm twitching that resolves, thirty minutes spent speaking with ICU team, reviewing CT, and consulting neurology. (50 minutes) On postoperative day eight, the patient develops right hemiparesis, speech arrest and obtundation. She is intubated for airway protection. CT shows no hemorrhage, but CTA shows proximal middle cerebral artery (MCA) spasm; patient is taken to the angio suite for diagnostic angiography, left MCA angioplasty and injection of verapamil. On postoperative day 10, the patient becomes more lethargic and the CT now shows tiny now shows tiny hypodensities in both anterior cerebral artery (ACA) territories; patient is taken to the angio suite for diagnostic angiography and verapamil injection of bilateral ACAs. By postoperative day 14, the patient cannot be weaned from her EVD and a VP shunt is placed. On postop day 15 ten minutes are spent rounding on the patient and discussing issues related to discharge. On postoperative day 30, she is seen and her sutures are removed. On postoperative day 57, the patient develops fevers, nuchal rigidity, and a tap of her VP shunt reveals gram positive cocci; she is taken to the OR for VP shunt removal and EVD placement. She remains in the ICU for 11 days to ventricular drainage and antibiotic treatment. On postoperative 69 she returns to the OR for VP shunt replacement.

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

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

Day	Procedure/Service	Time	CPT Code	CPT coding w/G-codes
-1	Evaluation, review CT and CTA, discuss plan for surgery	60 min	99255	99255
0	Left craniotomy for clipping of aneurysm, right frontal EVD placement	6.0 h	61697 61210	61697 61210
1	Rounds, review of CT	30 min	N/C*	GXXX3 × 3 units
2	Rounds, discussion with ICU & Endocrine teams	30 min	--	GXXX3 × 3 units
3	Rounds, initiate antiseizure treatment and EEG, neurology consultation	50 min	--	GXXX3 × 2 units GXXX7 × 3 units
4	Rounds, review Neurology recommendations	30 min	--	GXXX3 × 3 units
5	Rounds, EVD management	30 min	--	GXXX2 × 3 units
6	Rounds, review CT, EVD management	30 min	--	GXXX2 × 3 units
7	Rounds, EVD management	20 min	--	GXXX2 × 2 units
8	Rounds, CT review, angiography and treatment of left MCA spasm with angioplasty	4 h	61640 36224 36226	61640 36224 36226 GXXX3 × 6 units
9	Rounds, CT review	45 minutes	--	GXXX2 × 3 units
10	Rounds, CT review, angiography and treatment of bilateral ACA spasm with spasmolytic infusion, with exam after angiography and discussion with family	5 h	61650 +61651 36226	61650 +61651 +336226 GXXX3 × 6 units
11	Rounds, EVD management, review CT	30 min	--	GXXX3 × 3 unit
12	Rounds, EVD management	30 min	--	GXXX2 × 3 units
13	Rounds, EVD management	20 min	--	GXXX2 × 2 units
14	Rounds, VP shunt placement	2 h	62223	62223 GXXX2 × 2 units
15	Round, discharge	15 min		GXXX1
30	Follow up visit, suture removal	15 min		GXXX5
57	ED evaluation, shunt removal with EVD placement	3 h	62256	62256 GXXX3 × 3 unit
58	Rounds, EVD management	30 min	--	GXXX2 × 3 units
59	Rounds, EVD management	20 min	--	GXXX2 × 2 units
60	Rounds, EVD management	20 min	--	GXXX2 × 2 units
61	Rounds, EVD management	20 min	--	GXXX2 × 2 units
62	Rounds, EVD management	20 min	--	GXXX2 × 2 units
63	Rounds, EVD management	20 min	--	GXXX2 × 2 units
64	Rounds, EVD management	20 min	--	GXXX2 × 2 units
65	Rounds, EVD management	20 min	--	GXXX2 × 2 units
66	Rounds, EVD management	20 min	--	GXXX2 × 2 units
67	Rounds, EVD management	20 min	--	GXXX2 × 2 units
68	Rounds, EVD management	20 min	--	GXXX2 × 2 units
69	Rounds, EVD management, VP shunt replacement	2 h	62223	62223 GXXX2 × 2 units
70	Rounds, CT review	20 min	--	GXXX1 × 2 units

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

- **Neurosurgical Case Example #3 — Lumbar Spinal Fusion for Traumatic Fracture**. A 72 year old man is a passenger in a motor vehicle accident. On arrival in the emergency department (ED) he has severe back pain, and a CT of the lumbar spine reveals a traumatic fracture involving L1 with compression and instability. It is recommended that the patient undergo T11-L3 posterior instrumented fusion with decompression at L2. On postoperative day one, the patient is examined, post-op CT to evaluate hardware is reviewed, and the patient still has significant sanguineous drainage from drains placed at surgery (30 minutes). On postoperative day two, thirty minutes are spent examining the patient, removing the drains, coordinating with orthopedics (which is treating the patient's tibia-fibula fracture) and the trauma team (which is still evaluating the patient for a conservatively-managed splenic laceration). On postoperative day three, the patient is seen on rounds and care is coordinated with orthopedics and physical therapy (20 minutes); later in the day the patient has an episode of desaturation while in bed. Thirty minutes are spent coordinating with the hospitalist on-call, who is evaluating the patient for possible pulmonary embolism (PE); anticoagulation management is discussed, and the chest CT is reviewed — which fortunately does not show a PE but rather atelectasis. On postoperative day four, the patient is seen on rounds with family now at the bedside; 40 minutes are spent discussing physical therapy, need for rehabilitation, and plans for long-term care. On postoperative day five, the patient is discharged to rehabilitation, but on postoperative day seven, the patient is brought back to the ED because of urinary retention. A CT scan is obtained in the ED, and thirty minutes are spent reviewing the images electronically, communicating with the ED about the possibility of cauda equina, and eventually the patient is admitted to Medicine for medication-related bladder atonia. On postoperative day eight the patient is seen and reassured, and sutures are removed at the bedside. (30 minutes) On postoperative day 30, the patient is seen in the office; he continues to wear his brace, but the family has multiple questions about whether the patient will be able to return to independent living or require long-term care because of persistent confusion, and a referral is made to neurology for evaluation of possible dementia along with scheduling of a head CT scan to rule out a delayed intracranial process (45 minutes). The head CT is reviewed the next day, and the family is called to relay the findings which are reassuring. (10 minutes) On postoperative day 60, the patient returns to clinic doing much better having been discharged from rehabilitation; spine x-rays are reviewed, and the patient's brace is removed. The patient is seen on postoperative day 90, to assess his recovery, and he is doing well.

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

Day	Procedure/Service	Time	CPT Code	CPT coding w/G-codes
-1	Evaluation, review CT, discuss plan for surgery	45 min	99254	99254
0	T11-L3 posterior instrumented fusion with L2 decompression	4.0 h	22612 22614 × 3 63047 22842 20936 20930	22612 22614 × 3 63047 22842 20936 20930
1	Rounds, review of CT and pain management	30 min	N/C*	GXXX2 × 3 units
2	Rounds, remove drains, coordinate post-op care with Orthopedics and Trauma Surgery	30 min	--	GXXX2 × 3 units
3	Rounds, discuss therapy plans with Orthopedics and PT; Review CT chest, coordinate with hospitalist	20 min 30 min	--	GXXX2 × 2 units GXXX7 × 3 units
4	Rounds, family discussion	40 min	--	GXXX2 × 4 units
5	Rounds, discharge management	20 min	--	GXXX1 × 2 units
7	Discuss presentation with ED and hospitalist, review CT	30 min	--	GXXX7 × 3 units
8	Rounds, suture removal, reassure patient and family	30 min	--	GXXX2 × 3 units
30	Counsel patient and family; arrange neurology referral and order CT	30 min	--	GXXX6 × 3 units
31	Call patient and family about CT results	15 min	--	GXXX7 × 1 unit
60	Examine and counsel patient, review x-rays, remove brace	30 min	--	GXXX5 × 3 units
90	Examine and counsel patient	20 min	--	GXXX5 × 2 units

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

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

Alternative to G-Code Proposal

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

If, however, CMS insists on proceeding with the claims-based data collection plan, the AANS and CNS would recommend that CMS build on existing mechanisms by using the RUC survey process and tracking postoperative visits using CPT Code 99024. This collaborative approach is well understood and could serve as the basis of an augmented data collection effort that would gather information from a representative sample of surgeons providing 10- and 90-day global surgery services. As the RUC has pointed out, it is important to consider the math regarding global surgical services and the likely low return on investment from requiring all physicians reporting these services to use the G-codes for every

procedure. There are currently 4,239 CPT codes with global surgical packages in the Medicare physician fee schedule. According to 2015 Medicare utilization, there are only 110 10-day global and 149 90-day global codes performed more than 10,000 times. It, therefore, seems reasonable for CMS to identify a targeted subset of CPT codes that meet a minimum utilization threshold and from there identify an appropriate representative sample of physicians from whom to collect data.

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

Given these statistics, we agree with the RUC that data collection should be limited to a targeted subset of procedures. Furthermore, it is not necessary to distinguish the level of service in a claims collection process at all, as there is no identified problem to solve regarding the level of E&M bundled into the global surgical period. While we understand that MACRA requires CMS to obtain data on both the number and level of visits in the global surgical period, we nevertheless believe there is absolutely no need to require all physicians reporting 10- and 90-day global services to use the complex new G-codes. Rather, CMS could use the existing 99024 code, which is readily available and incorporated in electronic health record and billing systems, and can be used to collect the number of visits. If necessary, data on the level of visits can be obtained through an additional RAND survey of practitioners.

Prong Two: Survey of Large Representative Sample of Physicians

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

Prong Three: Accountable Care Organizations (ACOs) Data Collection

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

Special Requirement for Teaching Hospitals

CMS has asked for comments on whether special provisions are needed to capture the pre- and postoperative services provided by residents. To this end, the agency has recommended that any

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

Timeline for Implementation

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

Payment Withhold

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

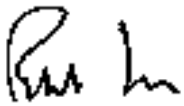
CONCLUSION

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

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

Thank you for considering our comments. As always, we recognize the hard work and expertise of the many individuals involved in Medicare policy. If you have any questions or need additional information, please contact us.

Sincerely,



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Enclosure: Appendix — Global Surgery Survey Results

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APPENDIX

GLOBAL SURGERY SURVEY RESULTS

See Attached

Survey on Global Surgery Data and Reporting Requirements

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

Prepared by the

Surgical Coalition

August 2016

Medicare's Global Surgery Payment Policy

Background

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

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

Medicare's Burdensome Data Collection Plan

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

Proposed Global Service Codes

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

Surgeons Must Make Major Practice Changes

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

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

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

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

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

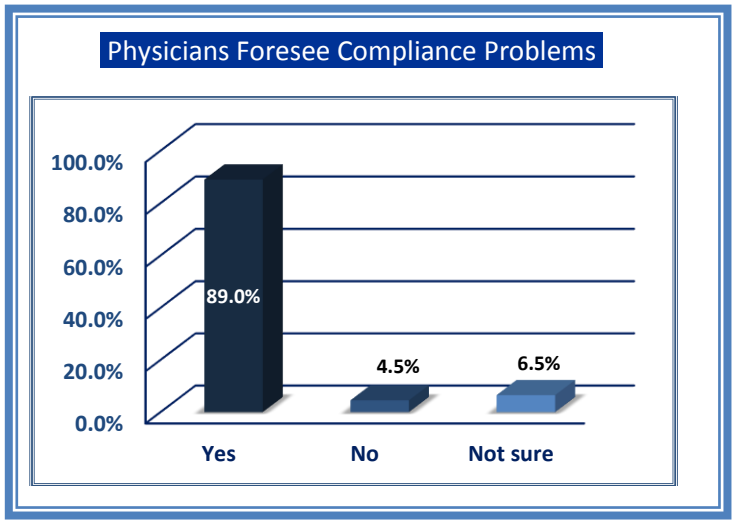
The study's results make it clear that this all-physician, all-services claims-based approach will be a costly and burdensome initiative that will likely yield incomplete and unreliable information.

A Costly Experiment

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

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

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



In Surgeons' Own Words

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

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

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

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

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

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

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

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

Ophthalmologist in a small, single specialty practice in the Midwest

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

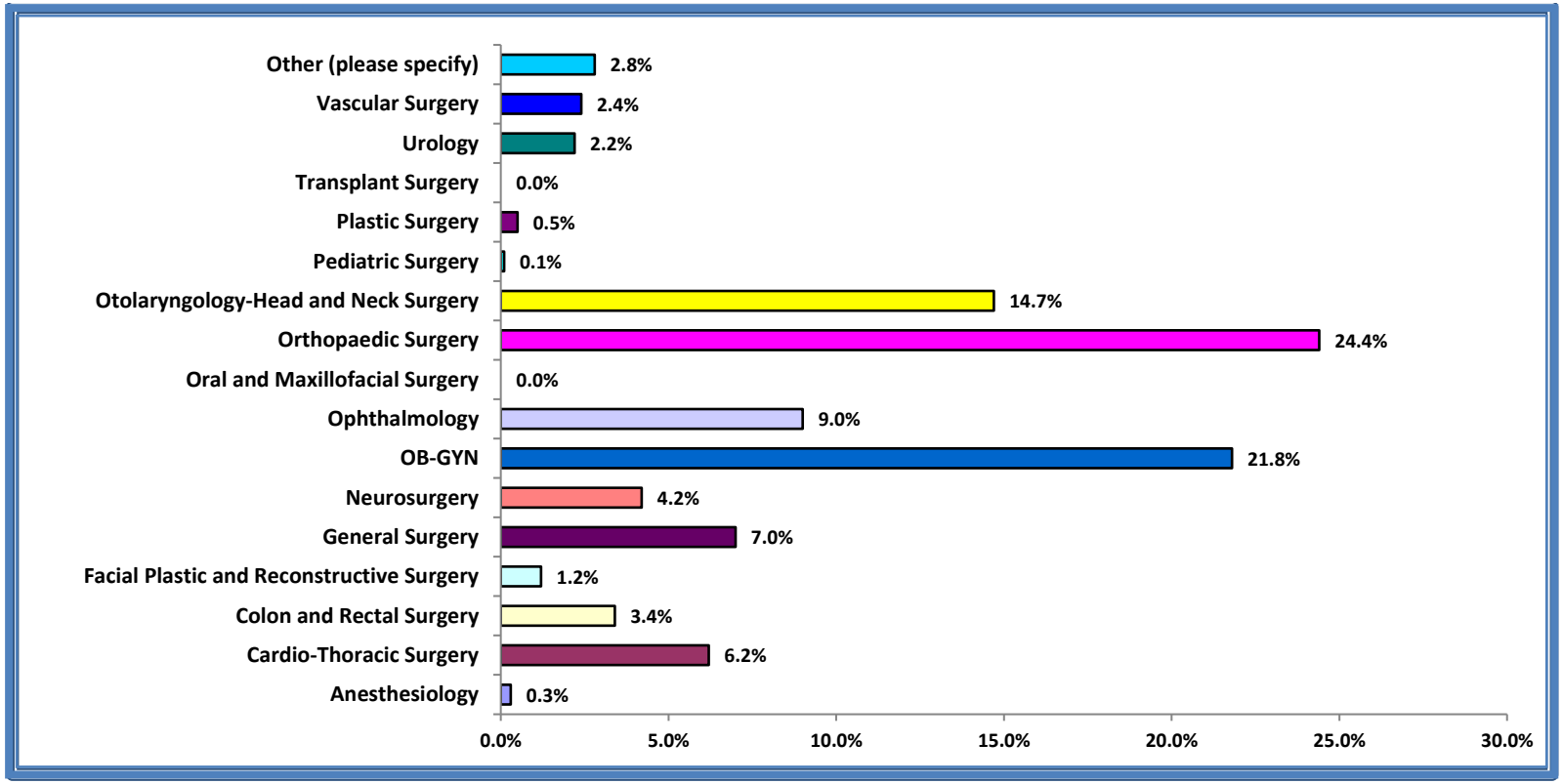
OB-GYN in a small, single specialty private practice in the Northeast

Survey Methodology

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

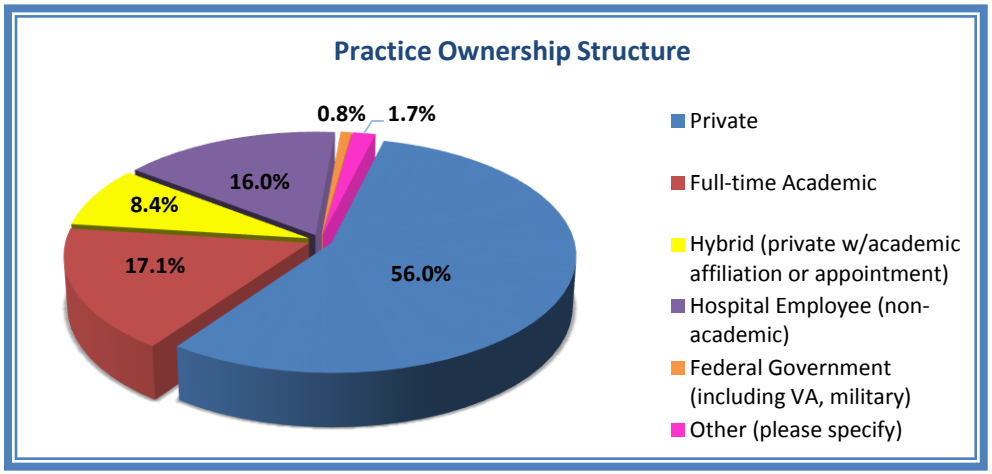
Demographics

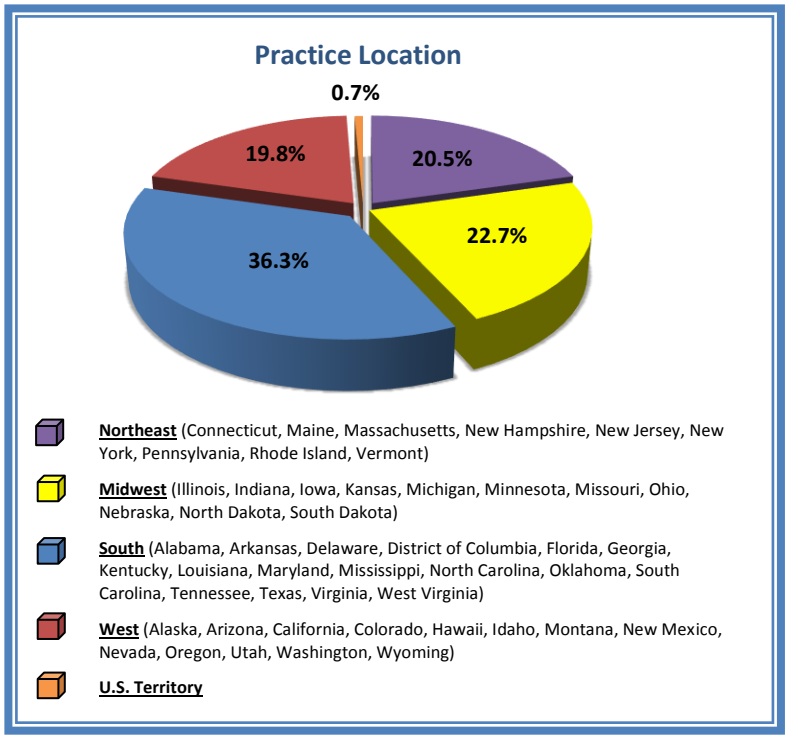
Surgeons and other physicians from approximately 25 specialties completed the survey, including: Anesthesiology, Breast Surgery, Cardio-Thoracic Surgery, Colon-Rectal Surgery, Dermatology, Facial Plastic Surgery, General Surgery, GYN Oncology, Hand Surgery, Neurosurgery, OB-GYN, Ophthalmology, Oral Surgery,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



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

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





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

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

Participating Organizations:

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

More Information:

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