Why CMS' plan to unbundle global surgery periods should be scrapped

A close-up look at ACOG's efforts to defeat the plan, which would have an annual cost of $95 million and necessitate the filing of 63 million additional claims

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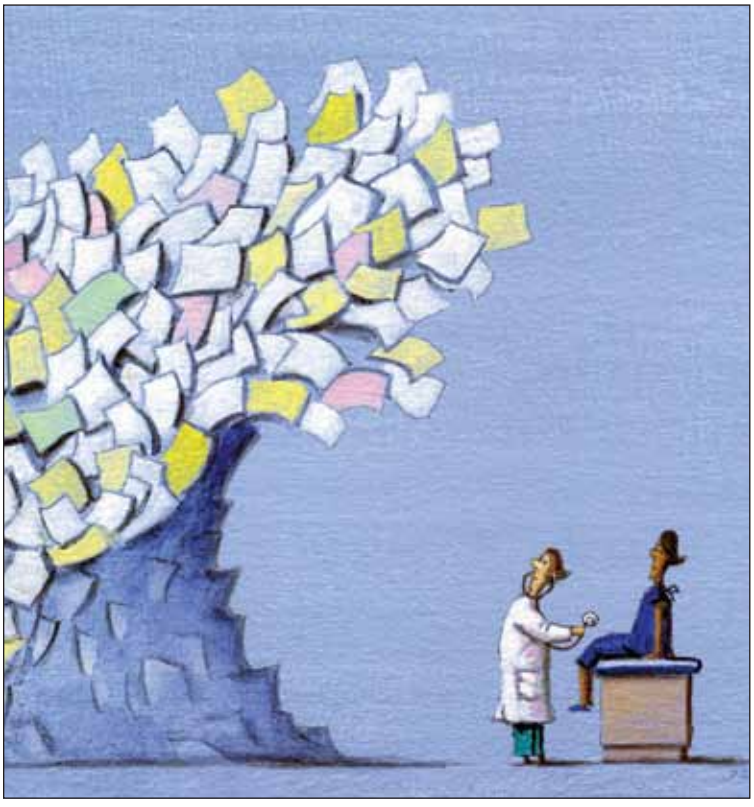

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Sometimes it's difficult to figure out which way is forward. For the past few years, private insurers and the federal government (through the Medicare program) have been experimenting with and putting in place different ways of paying physicians for the care they provide. Many alternatives are designed to increase value for our nation's health care dollars and improve quality of care, often through care coordination. Most involve different ways of "bundling" care—paying a single sum for a patient's episode of care rather than separate payments each time a physician encounters a patient.

For more than 20 years, Medicare has bundled most surgeries, paying 1 sum to the physician and requiring only 1 copayment from the beneficiary patient. In this way, when a patient needs surgery, Medicare pays the surgeon 1 payment for preparation the day before surgery, for the surgery itself, and for either 10 or 90 days of follow-up care, depending on the specific procedure involved (**TABLE 1**, page 16). Similarly the patient has had 1 copay for the entire episode of care. This bundling is called global surgical codes, and it applies to coding, billing, and reimbursement.

This approach may change soon—and not for the better. In this article, I describe how the federal Centers for Medicare and Medicaid Services (CMS) plan to eliminate global surgery bundling, as well as the efforts under way by the American

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ILLUSTRATION: PAUL ZWOLAK FOR OBG MANAGEMENT

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TABLE 1 CMS description of 10- and 90-day global codes

Minor procedures: 10-day postoperative period

- No preoperative period
- Visit on day of the procedure is generally not payable as a separate service
- Total global period is 11 days. Count the day of surgery and 10 days following the day of the surgery

Major procedures: 90-day postoperative period

- 1 day preoperative included
- Day of the procedure is generally not payable as a separate service
- Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery

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Under the CMS plan to eliminate surgical bundling, patients will have a copay for each physician intervention

Congress of Obstetricians and Gynecologists (ACOG) and other organizations to stop the proposed change.

The CMS plan to eliminate surgical bundling

In a significant twist from the trend toward bundling and care coordination, CMS finalized its proposed policy in its 2015 Medicare Physician Fee Schedule final rule to transition all 10- and 90-day global surgical codes to 0-day global surgical codes by 2017 and 2018, respectively. Beginning in 2017 for 10-day global codes and 2018 for 90-day codes, physicians will be paid separately for the day of surgery and for evaluation and management (E&M) provided on the day before and any days after. Patients will have copays for each physician intervention.

CMS has decided to move forward with this change despite overwhelming concern and opposition on the part of both patients and physicians. This change would affect more than 4,200 services on the Medicare Physician Fee Schedule—well over one-third of the 9,900 current procedural terminology (CPT) codes.

The new codes and increased paperwork and billing are daunting, and would result in an estimated 63 million additional claims per year to account for postsurgical E&M services. The cost to CMS alone for this huge new mountain of claims may be as high as $95 million per year. Moreover, under the new system, patients may not return for the full range of follow-up care needed if they get billed for every visit, possibly resulting in poorer outcomes.

CMS' justification for unbundling

CMS argues that this change is needed because many surgeons are failing to provide as much care (as many E&M follow-up visits) as they're paid to deliver under the 10- and 90-day codes. As evidence, CMS points to 3 reports published by the Department of Health and Human Services Office of Inspector General:

- An April 2009 report from the field of ocular surgery found that physicians provided fewer E&M services than were included in 201 of 300 examined global surgery fees. The cost of these undelivered services was approximately $97.6 million.[1]
- A May 2012 report from the field of cardiac surgery found that physicians provided fewer E&M services than were included in 132 global surgery fees of the 300 surgeries examined. The cost: $14.6 million.[2]
- Another May 2012 report, this one from the field of musculoskeletal surgery, found that physicians provided fewer E&M services than were included in 165 global surgery fees of the 300 surgeries examined. The cost for these undelivered services: $49 million.[3]

Based largely on these reports, CMS has determined that it cannot verify the number of visits, level of service, and relative costs of the services included in a global package, in large part because the current valuation methodology relies on survey data estimating the resources used in a typical case, instead of on actual data.

In each of these reports, the Inspector General also found smaller numbers of cases where surgeons provided *more* E&M care than was covered under the global payment. In each report, the Inspector General suggests that CMS should do more to identify and correctly value misvalued codes. ACOG Vice President for Health Policy Barbara Levy, MD, who is also chair of the

Relative Value Scale Update Committee, or RUC, makes a compelling case that the RUC has identified and corrected many global surgical codes since these reports were issued and is in the process of revising more codes. She also argues that the RUC is the appropriate place to address these issues.

Policy analysis finds that total RVUs would decline

CMS has indicated that it intends to use a formula for converting the 10- and 90-day global services into 0-day services by simply reducing the work relative value units (RVUs) for the service by the number of work RVUs in the postoperative visits. The American College of Surgeons asked Health Policy Alternatives (HPA), a consulting firm, to analyze the CMS decision. HPA found that "systematically convert[ing] all global surgical codes to 0-day global codes by backing out of the bundled E&M services reduces the total RVUs and each component (work, practice expense, and malpractice) for surgical codes. Specifically, **for surgical specialties,** the impact of this transition on all Medicare reimbursed codes results in the following reductions:

- overall payment decrease of 1.8%
- payment decrease of 0.8% for work
- payment decrease of 2% for practice expense
- payment decrease of 9.2% for malpractice.

This modeling resulted in a total overall payment increase of 0.1% **for generalists** and a payment increase of 0.3% **for medical specialists.**"[4]

HPA's findings related to the malpractice component are especially interesting for the ObGyn specialty. "Model results demonstrate that this policy results in significant redistribution of malpractice away from the main specialty provider of the surgical procedure into the entire group of providers (surgical and nonsurgical)," notes the HPA report.[4] "Most impacted will be specialties with higher malpractice expenses, such as neurosurgeons and cardiac surgeons."[4] We could add ObGyns to that list.

ACOG cites numerous objections

ACOG is deeply involved in opposing this new CMS policy and preventing it from ever going into effect, working on our own, in coalition with our medical organization colleagues and patient organizations, and working closely with the US Congress.

ACOG and 28 other medical organizations, including the American Medical Association (AMA), summarized our opposition in a letter to US House and Senate Democratic and Republican leaders in December 2014, saying that this new policy:

Detracts from quality of care, impedes patient access, and complicates patient copays

- Patients will be responsible for copays on each service, including follow-up visits. This could considerably increase the administrative burden on patients. Worse, it could discourage them from returning for needed follow-up care.
- In the hospital critical care setting, the global payment structure allows the surgeon to oversee and coordinate care related to the patient's recovery. Without the global structure, care will be fragmented and providers may compete to see patients and bill for the care they provide.

Undermines Medicare reform initiatives

- CMS initiatives for payment are all moving toward larger bundled payments. Deconstruction of the current payment structure for physicians is counterintuitive to the end goal of providing more comprehensive and coordinated care for the patient.
- Current bipartisan, bicameral legislation to repeal and replace the flawed sustainable growth rate formula calls for "a period of stability" in physician pay to allow physicians to transition to alternative payment models. The proposal to unbundle global surgical periods will add new complexities to an already flawed system and stymie progress.

Increases administrative burden

- The administrative burden on surgical practices and CMS (and its contractors) will be significant. Eliminating the global

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Under the plan to unbundle global surgery periods, surgeons will have less ability to collect information on patient outcomes

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TABLE 2 Other postoperative care services currently bundled into global surgical packages

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

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Without global periods, a one-size-fits-all approach to professional liability insurance will be unsustainable and result in great disparities between actual and realized malpractice costs for many physician specialties

package will result in 63 million additional claims per year, adding unnecessary costs to our health care system.

Obstructs clinical registry data collection and quality improvement

- Surgeons will have less ability to collect information on patient outcomes in clinical registries, undermining many of the most meaningful quality improvement initiatives.[5]

Additional ACOG concerns

ACOG added these concerns to our opposition to the CMS plan:

- The change will not accurately account for physician work, practice expense, and malpractice risk for services performed.
- Thousands of new codes and/or values will need to be created for postoperative care because the supplies and equipment needed for postoperative care are not included in the E&M codes that will be used to report in-hospital and outpatient postoperative services (**TABLE 2**).
- Liability costs of a specific service should be derived from those of the performing specialties. Under the CMS plan, the liability costs associated with postoperative work would be removed from the primary service and artificially diluted by the wide mix of specialties performing all types of E&M services. Without global periods, a one-size-fits-all approach to professional liability insurance will be unsustainable and result in great disparities between the actual and realized malpractice costs for many physician specialties.

We have important allies

The American Association of Retired Persons (AARP) joined us in September 2014, when it formally asked CMS to abandon this new policy. In a letter to CMS Administrator Marilyn Tavenner, AARP noted that, "from a beneficiary perspective, we are concerned that this unbundling could produce considerable confusion and cause beneficiaries to receive multiple explanations of Medicare benefits (and incur separate cost-sharing obligations) related to a single surgical procedure....[G]iven the obvious methodological uncertainty and complexity involved in determining appropriate values for a very large number of 'new' 0-day global services, and the likely confusion surrounding the resulting increase in Medicare claims, AARP has serious doubts regarding the benefit of this unbundling proposal. We suggest [that] CMS consider other available alternatives, including the re-valuation of global services whose current values are believed to be incorrect."[6]

Also in September, 27 Republican and Democratic members of Congress wrote a strong letter to CMS echoing the medical community's concerns. The letter and many months of congressional leadership have been spearheaded by Representatives Larry Bucshon, MD, and Ami Bera, MD—demonstrating the value of having physicians in elective office. Other physician members of Congress who have provided outstanding leadership include ACOG Fellows and Representatives Michael Burgess, MD, and Phil Roe, MD, as well as Representatives Tom Price, MD; Andy Harris, MD; Joe Heck, DO; Charles Boustany, MD; Raul Ruiz, MD; and Dan Benishek, MD.

This important group of physician leaders, ACOG, AARP, and the surgical community are hard at work to derail or significantly delay what most physicians and policy analysts see as a very bad idea.

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Congress takes action

In April 2015, Congress passed HR2, the Medicare Access and CHIP Reauthorization Bill, which most notably repealed the Medicare Sustainable Growth Rate formula. Included in this law is an important provision to halt implementation of CMS' plan to unbundle all 10- and 90-day global codes.

Section 523 of that law requires CMS to periodically collect information on the services that surgeons furnish during these global periods, beginning no later than 2017, and use that information to ensure that the bundled payment amounts for surgical services are accurate. The Secretary of Health and Human Services is given the authority to withhold a portion of payment for services with a 10- or 90-day global period to incentivize the reporting of information. The Secretary can stop collecting this information from surgeons once the needed data can be obtained through other mechanisms, such as clinical data registries and electronic medical records.

Congressmen Bucshon and Bera championed this provision, along with nearly all physician members of the US House of Representatives. This change ensures a thorough, data-driven approach to appropriately valuing surgical services, including those provided by ObGyn subspecialists, such as urogynecologists and gynecologic oncologists.

Acknowledgment

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References

1. Department of Health and Human Services, Office of Inspector General. Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005. A-05-07-00077. Washington, DC: Department of Health and Human Services; April 2009.
2. Department of Health and Human Services, Office of Inspector General. Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided. A-05-09-00054. Washington, DC: Department of Health and Human Services; May 2012.
3. Department of Health and Human Services, Office of Inspector General. Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided. A-05-09-00053. Washington, DC: Department of Health and Human Services; May 2012.
4. Summary of Initial Modeling Results of the CMS Policy to Transition 10- and 90-Day Global Surgery Codes to 0-Day Global Surgery Codes. Washington, DC: Health Policy Alternatives; January 9, 2015.
5. American Congress of Obstetricians and Gynecologists joint letter to Congress; December 2, 2014.
6. American Association of Retired Persons letter to Marilyn Tavenner, Administrator, Centers for Medicare and Medicaid Services; September 2, 2014.

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