Please Provide Responses to the Fields Below Electronically to be Accepted

Medicare Red Tape Relief Project
Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: August 25, 2017
Name of Submitting Organization: American Association of Neurological Surgeons/Congress of Neurological Surgeons
Address for Submitting Organization: 725 15th Street, NW, Suite 500, Washington, DC 20005
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Submitting Staff Phone: 202-446-2024
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Statutory ☒ Regulatory ☒

Please describe the submitting organization's interaction with the Medicare program:

The American Association of Neurological Surgeons (AANS), founded in 1931, and the Congress of Neurological Surgeons (CNS), founded in 1951, are the two largest scientific and educational associations for neurosurgical professionals in the world. Timely access to quality neurosurgical care is essential to the health and well-being of society, and as the voice of neurosurgery before legislative, regulatory and other health care stakeholders, the AANS and CNS advocate for our specialty and patients on a wide-variety of health care policy matters, including Medicare policy. Neurological surgery is the medical specialty concerned with the prevention, diagnosis, treatment and rehabilitation of disorders that affect the entire nervous system, including the spinal column, spinal cord, brain and peripheral nerves. For more information, please visit www.aans.org, www.cns.org and www.neurosurgeryblog.org.

Please use the below template as an example of a submission regarding statutory or regulatory concerns, and submit any further concerns past those listed below in a separate Microsoft Word document in the same format. Submissions must be in the requested format or they will not be considered.

In the case of listed Appendices, please attach as PDF files at the end of the submission, clearly marked as "Appendix [insert label]"

In the case of a multitude of submissions, it is recommended that they be submitted in order of priority for the submitting organization or individual.

Short Description: Medicare Global Surgery Data Collection (Priority Issue #2)

Summary:

The Medicare Access and CHIP Reauthorization (MACRA) Act (Pub.L. 114-10, Section 523) requires the Centers for Medicare & Medicaid Services (CMS) to collect information on the number and level of medical visits furnished during the 10- and 90-day global surgery period from a "representative sample" of physicians and in 2019 use this information to improve/validate the accuracy of the valuation of surgical services.

In the CY 2017 Medicare Physician Fee Schedule (PFS), CMS set forth a global codes data collection policy consisting of three components: (1) claims-based data reporting; (2) a survey of practitioners; and (3) data collection from accountable care organizations (ACOs). For claims-based reporting, CMS

finalized a policy whereby practitioners who are in groups of 10 or more practitioners and who are located in any one of nine specified states — Florida, Kentucky, Louisiana, New Jersey, Nevada, North Dakota, Ohio, Oregon and Rhode Island — are required to report CPT code 99024 for every post-operative visit that they provide related to any CPT code on a list of 293 10- and 90-day global codes (30 of which are services provided by neurosurgeons) specified by CMS. Additionally, few details are known about the other two components, namely, the survey of practitioners and data collection from ACOs.

CMS began the implementation of this onerous data collection process on July 1, 2017, despite the fact that the agency has failed to (1) provide a detailed plan for data validation; (2) provide answers to a whole host of outstanding questions; (3) assure physicians that claims submitted with the required data will be captured; and (4) adequately educate physicians subject to the data collection requirements.

Related Statute/Regulation:

- 42 USC 1395w-4(c)(8)
- CY 2017 Medicare Physician Fee Schedule, 81 Fed. Reg. 80209-80225
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Global-Surgery-Data-Collection-.html

Proposed Solution:

Ideally, Congress should repeal Section 523 of MACRA as it is unnecessary. CMS already has in place a process for reviewing and adjusting the value of surgical services. At the very least Congress or CMS should delay the global surgery data collection project — both claims data and the provider survey — until such time as CMS has addressed outstanding project issues and conducted adequate provider education. Additionally, the agency should avoid using any data collected in 2017 to revalue global services in 2019, particularly until the validity of such data can be ascertained. Furthermore, CMS should suspend the practitioner survey until it has been thoroughly vetted and the specialties to be surveyed have had an opportunity to review it and provide feedback. Finally, if CMS is able to collect useful data (which we doubt), the agency should refrain from modifying values for those CPT codes subject to data collection outside of the well-established American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) process.

Appendix:

- April 20, 2017 Surgical Coalition Letter to HHS Secretary Tom Price, MD

APPENDIX

April 20, 2017 Surgical Coalition Letter to HHS Secretary Tom Price, MD

April 20, 2017

The Honorable Thomas Price, MD
Secretary
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: **Collecting Data on Resources Used in Furnishing Global Services**

Dear Secretary Price and Ms. Verma:

On behalf of the 23 undersigned organizations of the surgical coalition, we write to express concern with the implementation of the Centers for Medicare & Medicaid (CMS) policy requiring data collection on global services as finalized in the calendar year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule. Our organizations put the welfare of our surgical patients above all else, and we urge CMS to view policy changes through the lens of any potential impact on patients by focusing initially on the best care delivery models and then developing appropriate payment models to facilitate these care delivery models. We support policy changes that improve patient care and increase the accuracy of physician reimbursement, but CMS' data collection policy on global codes currently lacks sufficient information on its implementation and has already posed a serious barrier to the collection of accurate data.

Before data collection begins, we ask that CMS share a detailed plan for data validation, provide answers to outstanding questions, and assure providers that all claims submitted with the required data will be captured. **We do not think it is appropriate to begin the collection of data on July 1, 2017, before CMS has addressed these issues and provided adequate time for provider education.** If CMS continues with its plan to collect data even though it has not provided sufficient information in advance that allows for physician education and familiarity necessary to comply with the policy, the data will be inherently flawed and of low statistical quality. We strongly urge the Agency to avoid using such data to revalue global services starting in 2019.

Background – MACRA and the Medicare Physician Fee Schedule

Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to use rulemaking to obtain information needed to value surgical services from a representative sample of physicians, and it requires that the data collection begin no later than January 1, 2017. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery, as appropriate. Beginning in 2019, the information

collected, along with any other available data, must be used to improve the accuracy of the valuation of surgical services.

In the CY 2017 MPFS, CMS set forth a global codes data collection policy consisting of three components: (1) claims-based data reporting; (2) a survey of practitioners; and (3) data collection from accountable care organizations (ACOs). For claims-based reporting, CMS finalized a policy whereby practitioners who are in groups of 10 or more practitioners and who are located in any one of nine specified states would be required to report CPT code 99024 for every post-operative visit that they provide related to any CPT code on a list of 293 10- and 90-day global codes specified by CMS. This mandatory data collection begins July 1, 2017. Additionally, few details are known about the other two components, namely, the survey of practitioners and data collection from ACOs. Although MACRA allows a 5 percent withhold in payment for those practitioners who fail to report, we appreciate that CMS has not implemented this penalty.

Current Policy Implementation Hurdles

Claims-based data reporting of post-operative visits will be required starting July 1, 2017; however, **many aspects of this policy require clarification, making it difficult to educate the members of our organizations to prepare for a July 1 start date**. Some unanswered logistical and policy questions are described in the list below:

Implementation Issues Regarding Claims-Based Reporting of Post-Operative Data
Definitions
• The rule requires that practitioners in groups of 10 or more practitioners must report post-operative visits using 99024, but the term "practitioner" is not defined. This definition is needed in order for our members to determine whether they are required to report.
• A "group" is defined not as practitioners sharing the same tax ID number (TIN) as in all other cases of CMS reporting, but rather those who share business or financial operations, clinical facilities, records, or personnel. This is a confusing definition of a group for the purposes of this policy.
Logistical/Readiness
• Has CMS considered whether practitioners will be able to submit claims for 99024 for post-operative visits from any site of service? To collect an accurate number of the post-operative visits that are provided, practitioners must be able to report 99024 from all settings of care, not just ambulatory settings.
• Are all CMS contractors prepared to accept 99024?
• Who will educate clearinghouses and software vendors on the required 99024 reporting? We have heard anecdotally that some clearinghouses are rejecting 99024 claims. Our preliminary research has indicated that many clearinghouses have not been informed of this policy.

• If claims submission software or clearinghouses require that a monetary value be attached to 99024 codes (thereby preventing a claim from being rejected), would the CMS contractors have the capability of handling non-payable codes submitted with one penny attached?
Submission of Claims
• If a practitioner sees the patient twice in one day should two 99024 codes be submitted for two visits? Or are practitioners limited to submitting one 99024 per 24 hour period?
CMS Analysis of Data
• How will CMS keep the appropriate 99024 attached to the index procedure? This is especially important in cases where multiple CPT codes from the list of 293 codes are reported within the same global period.
• Has CMS developed a method for providers to confirm that all 99024 codes have been captured?
• How will CMS handle the data from practitioners who do not consistently report 99024? Despite best efforts at education, some practitioners will not reliably report 99024 as required. How will CMS take this into consideration?
• How will CMS handle procedures that are submitted with modifiers? There are a number of modifiers that are appended to surgery claims that impact the provision of post-operative care and that could significantly impact data collection.

We also have very little information regarding the survey of practitioners (the second component of global codes data collection). Some of the undersigned organizations have been contacted by the RAND Corporation (RAND) to nominate a member to be interviewed by RAND as it develops the survey. The CY 2017 MPFS final rule stated that the survey will be in the field by mid-2017, yet we do not know enough about the survey to begin educating our members on what to expect. In addition, it is critical that clinical experts from the specialties who will be surveyed have the opportunity to review and provide feedback on the survey design, methodology, content, and analysis. At this point, our understanding is that just one member of a selection of specialties will be interviewed and only those without payment expertise have been considered. We have many questions and concerns regarding the survey development and **we urge CMS not to move forward with this practitioner survey until it has been thoroughly vetted and the specialties to be surveyed have had an opportunity to review it and provide feedback**.

Even if CMS is able to collect useful data, which is of serious concern given the issues raised above, we do not believe that it is appropriate to use such data alone to improve the accuracy of 10- and 90-day global services. Despite possible CMS concerns regarding the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) process for valuing global codes, it is inappropriate to assign values to some CPT codes using a methodology that is completely independent from the RUC process. If CMS implements a valuation strategy outside of the RUC process, relativity

between CPT code values will be fundamentally disrupted, so **attempting to assign values outside of this relative value scale for some, but not all, CPT codes would be improper**.

Summary

We doubt that CMS will be able to achieve its intended goal to collect accurate and complete data that will improve the accuracy of global codes under this policy as it now stands. Given the significant implementation hurdles and the fact that there are less than three months before the mandatory claims-based data reporting is set to begin, **we do not believe it would be appropriate to begin the collection of data on July 1, 2017, unless CMS has addressed these issues raised by the undersigned organizations.** If CMS does move forward with its plan to collect data without providing enough information for adequate physician education, we recommend that the Agency not use flawed and misleading data to revalue global codes starting in 2019. Thank you for your consideration and your attention to this important issue for surgical patients and their physicians.

Sincerely,

American College of Surgeons
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 Congress of Obstetricians and Gynecologists
American Osteopathic Academy of Orthopedics
American Society for Metabolic and Bariatric Surgery
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of Plastic Surgeons
American Urogynecologic Society
American Urological Association
Congress of Neurological Surgeons
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Gynecologic Oncologists
The American Society of Breast Surgeons
The Society of Thoracic Surgeons