

Staving Off Elimination of the Global Period

To bundle or not to bundle: Is that the question?

BY GEORGE A. WILLIAMS, MD

Since the introduction of the Resource-Based Relative Value Scale (RBRVS), the Centers for Medicare and Medicaid Services (CMS) has assigned a global payment period to all surgical procedures. There are three global periods used by CMS: 000-day global (includes all services performed on the date of service), 010-day global (includes all services performed within 10 days from the date of service), and 090-day global (includes all services performed for 90 days within the date of service). The total valuation of the surgical procedure includes all physician services provided within the global period including postoperative care, as measured by the number and intensity of postoperative Evaluation and Management (E/M) services.

Various modifiers are used to report additional work, such as reoperations or events unrelated to the initial surgical procedure. Each surgical procedure is assigned a specific number of inpatient, day of discharge, or outpatient E/M services.

UNDERSTANDING THE RUC

The number of E/M services assigned to a surgical procedure is based on surveys performed by the Relative Value Scale Update Committee (RUC) of the American Medical Association. Using survey data to determine the components of a “typical” case, the RUC recommends to CMS a specific number of E/M services as a component of the total relative value unit (RVU) valuation for that case. CMS may or may not accept this valuation.

The RUC uses a process of magnitude estimation and relativity to create the total valuation. Magnitude estimation considers how a specific surgical procedure compares with other procedures in terms of time and intensity, so that the procedure is ranked in relativity compared with other procedures. Both similar and disparate procedures are compared. For example, valuation of a retinal detachment code (eg, 67108) is

At a Glance

- For CMS, the relative value of a surgical procedure is based on survey data identifying the components of a “typical” case.
- A plan by CMS to eliminate global periods, met with resistance from organized medicine, was addressed by Congressional action.
- Given that ophthalmic procedures require a higher-than-average number of postoperative visits, retina specialists must be particularly concerned about plans to eliminate the global period.

compared with other retinal detachment codes, other ocular surgery codes, and nonocular surgery codes. The key concept in this process is relativity—that is, how does one code relate to another?

ELIMINATION OF THE GLOBAL PERIOD

In 2014, CMS published a plan to eliminate all 010-day and 090-day global periods by 2018. In other words, all surgical procedures would be 000-day. At first glance, this seemed to be a stunning reversal of CMS policy to bundle more care into packages.¹ However, CMS indicated that there were significant concerns that the E/M services incorporated into the overall valuation were not being performed. CMS cited studies by the Office of the Inspector General that this was particularly true for cardiovascular surgery, orthopedics, and ophthalmology.²

This proposal created a firestorm of opposition from most of organized medicine, including the American Academy of Ophthalmology (AAO) and the American College of Surgeons (ACS). Multiple concerns were raised about the implications and unintended consequences of this unbundling. One prominent issue

“Ophthalmology is at the highest risk for problems from elimination of the global periods.”

concerned copayments for postoperative visits and the concern that patients might not return for postoperative care, particularly in the event of complications, due to the increased cost associated with more postoperative visits. Some were concerned about arcane issues of allocation of practice expense and professional liability in the postoperative period, and others worried that billing additional E/M services each visit would increase administrative burden.

The most important issue concerned the methodology for the revaluation of surgical procedures without the postoperative E/M services. CMS proposed to back out the value of postoperative visits by simply subtracting the cumulative RVU value of the E/M services from the total RVU value. This approach is known as *reverse building block*. The RUC adamantly opposes any systematic formula that adjusts the value of a service within a surgical global package based on any single component therein. The RUC works under the prevailing assumption that magnitude estimation is the standard for valuation of all physician services, including those with global surgical packages. Thus, the work values associated with E/M services in a code's global period are not necessarily added to the physician work value to determine the final work RVU. These services are proxies representing a physician's *typical* case. The RUC then employs magnitude estimation based on survey data to assign the work RVU and reviews the data to determine the typical E/M services provided in the global period. Thus, a reverse building block approach threatens to disrupt the relativity that is the underlying basis for the RBRVS.

Ophthalmology is at the highest risk for problems from elimination of the global periods. An analysis by the RUC found that, in 2013, ophthalmologists performed 4045906 procedures with total CMS payments of \$2091767440 distributed over 119 CPT codes. The vast majority of these payments were for codes with a 090-day global period.

This is the highest exposure in all of medicine, and the adverse implications of ophthalmic surgical procedure reimbursement are clear. As a result, the AAO played a crucial role in mobilizing opposition to the

CMS proposal. When it seemed clear that CMS intended to proceed with the plan for elimination of surgical global payments, the AAO, ACS, and other medical organizations turned to Congress for relief.

THE MACRA

This relief came with the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 that, in addition to ending the sustainable growth rate fiasco, also prohibited the implementation of CMS policy to transition all surgical global packages into 000-day global packages. The MACRA requires CMS to develop a process to gather the information needed to value surgical services from a representative sample of physicians, with data collection beginning 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. CMS is now soliciting comments regarding the kinds of auditable, objective data needed to increase the accuracy of its values for surgical services. Additionally, the agency is seeking comment on the most efficient means of acquiring these data.

There are currently 4256 CPT codes with surgical global packages in the Medicare payment schedule. Of the 473 services that have a 010-day global period, the average number of postoperative office visits included in the global package is one. Of the 3783 services that have a 090-day global period, the average number of postoperative office and hospital visits is three. Furthermore, according to 2014 Medicare utilization data, only 108 of the 010-day global and 152 of the 090-day global codes were performed more than 10 000 times.

The level of postoperative E/M visits must also be considered. On average, the global surgical packages have much lower levels of office and hospital visits compared with separately reported E/M visits.

CPT codes for established office visits range from 99211 to 99215, in increasing levels of complexity. The median established office visit code in a global surgical package is 99212, whereas the median level for separately reported visits is 99213. Only 1% of all established patient office visits in 010-day and 090-day global surgery packages have a visit level above a 99213, whereas 44% of all separately reported E/M visits are reported as a 99214 or 99215. These data strongly support the position that E/M global visits are at an appropriate level of intensity. Nonetheless, CMS plans to proceed with further analysis of the number and intensity of postoperative visits.

(Continued on page 24)

BUSINESS OF RETINA PENNSYLVANIA AVENUE UPDATES

(Continued from page 20)

WHAT'S NEXT?

During the next year, the RUC and CMS will continue to evaluate the issue of global periods. Already, the RUC uses the number of postoperative visits as a screen to identify potentially misvalued services. Complicated vitreoretinal surgical procedures commonly have a higher-than-average number of postoperative visits and therefore have recently been reevaluated. However, organized medicine has been able to present compelling survey data to support the higher number of visits.

The good news is that the misguided CMS policy to end surgical global periods has been stopped. The bad news is that the scrutiny will continue. ■

George A. Williams, MD, is a professor in and chair of the department of ophthalmology at Oakland University William Beaumont School of Medicine in Royal Oak, Mich.; director of the Beaumont Eye Institute; and a member of the Retina Today Editorial Board. He is the delegate for the American Academy of Ophthalmology to the American Medical Association's Specialty Society Relative Value Scale Update Committee and is AAO Secretary for Federal Affairs. Dr. Williams may be reached at gwilliams@beaumont.edu.



1. Mulcahy AW, Wynn B, Burgette L, Mehrotra A. Medicare's step back from global payments—unbundling postoperative care. *N Engl J Med*. 2015;372(15):1385-1387.

2. Department of Health and Human Services. Office of the Inspector General. Nationwide review of evaluation and management services included in eye and ocular adnexa global surgery fees for calendar year 2005 (A-05-07-0077). April 2009. oig.hhs.gov/oas/reports/region5/50700077.pdf. Accessed October 14, 2015.