MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Collecting Data on Global Surgery as Required by MACRA: Listening Session
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Contents

Operator: At this time I'd like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the feedback session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect.

I'll now turn the call over to Leah Nguyen. Thank you, you may begin.

Announcements and Introduction

Leah Nguyen: I'm Leah Nguyen from the Provider Communication's Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects listening session on collecting data on global surgery, as required by the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA. MLN Connects Calls are part of the Medicare Learning Network®.

This listening session provides an opportunity for CMS to learn from stakeholders about how to conduct the data collection required under Section 523 of MACRA. CMS is developing a proposal for implementing these new data collection requirements, including the definition of global periods, sampling approach, mechanisms for data collection, and definition of services furnished within the global period.

Before we begin, I have a few announcements. You should have received a link to the materials for today's call in previous registration email. If you have not already done so, please view or download the presentation and questions from the following URL: www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the January 20th call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these are available.

At this time I would like to turn the call over to Chava Sheffield from the Hospital and Ambulatory Policy Group, Division of Practitioner Services.

Presentation

Chava Sheffield: Good afternoon. This is Chava Sheffield. I'm here with Kathy Bryant, and we're working together on the data collection efforts under MACRA. The purpose of today's listening session is for us to hear from stakeholders about how CMS should meet the requirements to collect data, as required by Section 523 of MACRA.

The law requires that CMS collect information about the number and level of medical visits and other items and services related to the surgery and furnished during the global period. The purpose of today's call is not to discuss issues related to global surgery policy or to discuss whether the data should be collected. Rather, we are seeking guidance on how CMS should collect the data required by MACRA.

We are conducting the session to provide stakeholders with an opportunity to provide input early on in the process as we develop proposals for the CY 2017 PFS proposed rule. This will give

us the benefit of understanding stakeholder views and ideas as we develop proposals related to the data collection process.

Our goal is to gather information about the questions that we sent out. Since we have not yet developed our proposal, we will not be able to respond to questions regarding any potential proposals on today's call.

There are five issues on the agenda today. To get into the queue to answer a question on the first agenda item, you'll press star 1. And once we move on to the next question, the queue will be reset, and you will need to get in the queue again if you wish to respond to the next agenda item.

Due to the large number of questions and the number of individuals on this call, we invite each participant to speak for up to 3 minutes. If you do not get an opportunity to speak on today's call, please send an email with your comments to the mailbox MACRA_Global_Surgery@cms.hhs.gov, which is also listed on the last slide.

I'll turn it back to Leah.

Leah Nguyen: Thank you Chava. For this listening session, we would like to hear your feedback on five separate topics, which are listed on slide 3 of the presentation. Please wait until your topic is announced before getting into the queue to provide your comments.

Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before providing your feedback, please state your name and the name of your organization, and remember to pick up your handset to assure clarity. Please note your line will remain open during the time you are providing your feedback, so anything you say or any background noise will be heard in the conference.

Mechanisms for Capturing Services Typically Furnished during the Global Period

The first topic is "mechanisms for capturing the types of services typically furnished during the global period." Holley, we are ready to hear from our first caller.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please hold while we compile the roster.

Your first comment comes from the line of Sherry Smith.

Sherry Smith: Hi, this is Sherry Smith. I'm Director of Physician Payment Policy at the AMA and staff for the AMA Specialty Society RVS Update Committee. And there are members of the RUC that are on the line today to speak to each of the questions that you have raised.

I'll just say quickly on the first topic of the discussion of what data can be collected through claims processing or other mechanisms through the — the RUC discussed this on this past weekend at its meeting and would like to formally comment, and we will provide the comments in writing as well, that the current CPT code that is available, 99024, is available in claims

processing systems now, and it is specifically designed — defined to describe post-operative followup visits that are included in the surgical package.

We believe, in terms of claims processing, that that code — the collection of data from that code — is the most feasible, and that other data collection efforts should be — CMS should consider something like a portal or a survey of representative number of physicians to collect that information, which would include level or information on other things that are included in the surgical global, like additional supplies and other services, such as care management.

Finally, I just want to speak to the issue of the level of the E/M services that are in the global. Currently, 98 percent of the visits that are in surgical global packages are level 99212 or 99213 for office visits. So, we would argue that there is little benefit and a great deal of cost to trying — to any attempt to try to collect through claims processing the level of visits, and that CMS would be best served to use a portal or survey collection effort for — if you feel that you must collect level of visits. Thank you.

Leah Nguyen: Thank you.

Operator: Our next comment comes from the line of Chris Senkowski.

Chris Senkowski: Hello, my name is Chris Senkowski, and I represent the American College of Surgeons. I would speak to question 1 as similar to the — to what Sherry just discussed. We have thought through various scenarios whereby we could use claims to sort of capture some of the levels and visits. We feel that 99024 is an area of — where claims could report the number of visits, both on the hospital side and the office side.

We feel that in centers where the facility is owned by the hospital, where that billing might be easily — more easily tracked by CMS, that the length of stay could be seen from Part A payments, as well as at least to verify the number of visits. We also concur that trying to figure out the level of visits would be more difficult in that you would have to rely upon a survey as — in some form.

In regards to the other parts of question 1, we also feel like there may be a great deal of variable — what's mentioned at how much consistency there would be among patients with services provided in the pre- and post-period. And we think that, based on various regions of the country and various health-care scenarios, even within States, if you look at some of the health-care rankings by county, there's such variability that the representative sample would be very important in — even looking at length of stay based on socioeconomic factors and patient-care factors that might go beyond what you might see in an urban area versus a rural area. So we think that will show a fair amount of difference in the consistency of the work that's performed. And I'll stop there.

Leah Nguyen: Thank you.

Operator: Your next comment will come from the line of Jean Acevedo.

Jean Acevedo: Hi, thanks. So, I have a consulting firm that does a lot of chart audits. So, I concur with the AMA and the American College of Surgeons that 99024 is probably a familiar and

consistent way to capture the number of visits. Physicians do that routinely in their office. They'd have to get into a new habit for the most part of also communicating that to their billing staff to enter the code for their followup postsurgical visits in the hospital setting, whereas they don't consistently do that.

And then to the level of service, a couple of thoughts. One, it would seem that CMS could develop some HCPCS modifiers that could have — be appended to the 99024 code so that the level of service would be — could be communicated on the claim as well. And then just a note of caution for the physicians. However, and again, because we look at an awful lot of documentation, I know that because there's no billing requirements for the post-op visit physician's document, only what they feel clinically is appropriate. Nothing wrong with that 'cause, you know, obviously, in the current circumstances, which — but that does not reflect the total work that the physician has done during the encounter, because he or she is no longer concerned with levels of service, right?

So the community — the physician community — would just have to be educated. That same evaluation and management documentation requirements applied to each one of the modifiers. Just my thought for how you might be able to capture this via claims.

Kathy Bryant: So, can I ask a followup question?

Jean Acevedo: Sure.

Kathy Bryant: How consistent do you believe physicians are in using 99024? And does it vary when they are providing the post-op visits in the hospital versus when they are providing them in an office setting?

Jean Acevedo: Yes, so in the office setting, most surgeons — and my firm has been around for 16 years — we have physician practices throughout the country, so it's probably a fairly good representation as to what surgeons are doing today. In the office setting, I would say that the overwhelming majority are, for whatever their reasons, if only for data collection to be able to look in the system and say, "Well, when the heck was that patient in?" or "Did I see them once or twice?" you know, without looking in the chart. That 99024 is routinely used in the office setting.

It is the hospital followup setting, however, that, for whatever reason, it is not routine for physicians to bring back any type of billing/coding information to allow staff to capture the post-op visits there. So, that would indeed have to be something — a new habit — that physicians would get — need to be — get used to.

Kathy Bryant: OK.

Jean Acevedo: So I really believe — yes, so and I — you know, as I thought through this, it's like, how does CMS do this easily on both sides without the complex review of looking at records that would be required otherwise, if you don't do the claims, right?

Kathy Bryant: Thank you for your feedback.

Jean Acevedo: Sure, my pleasure.

Operator: Our next comment will come from the line of David Glasser.

David Glasser: Hi, this is David Glasser. I'm with the American Academy of Ophthalmology. Ophthalmologists, I think, have won the 90-day global lottery when you look at the spreadsheet. I — we agree in general with the comments made by AMA and ACS about 92014 being a mechanism for capturing the number of visits. But we have concerns about whether it is used properly, because physicians are not used to using it. And one of the mechanisms for capturing the number of post-op visits might be to sample large systems and practices that are using electronic health records that require entry of some CPT code for every visit.

And I think you'll get more accurate data from them than from trying to educate physicians, some of whom are going to learn more quickly than others and some of whom are already sort of maxed out on all of the Meaningful Use PQRS items.

The second issue is the intensity and amount of work. And 99024 does not have any way of capturing the amount of work, nor does it have any way of capturing practice expense issues. So, there again, it may be necessary to select a sample of willing participants in large groups to try to define those more accurately. Thank you.

Leah Nguyen: Thank you.

Operator: Our next comment will come from the line of Jugna Shah.

Jugna Shah: Hi there, I am with a consulting firm as well in Nimitt Consulting, Inc., and work with a lot of different providers across the country. I'm happy to hear folks mention 99024. That seems like a useful first place for CMS to look for data collection.

The other comment that I want to make is with respect to use of HCPCS codes or modifiers. I would encourage CMS to stay away from that to the extent possible and to go with existing CPT codes or creation of new CPT codes rather than HCPCS codes or requiring any kind of modifier usage. Thanks so much.

Leah Nguyen: Thank you.

Operator: Our next comment comes from the line of Barbie Hays.

Barbie Hays: Hi, this is Barbie Hays.

Operator: Barbie, your line is open.

Barbie Hays: Hello?

Operator: Yes, go ahead.

Barbie Hays: Hi, this is Barbie Hays from the American Academy of Family Physicians. Currently I am working with the coding and compliance strategist here at the American Academy of Family

Physicians, but I did work for multiple years in a multispecialty family practice setting. One of the sample issues that could be a problem is, surgeons not always are doing the full pre- and post-op packaging. So as far as sampling, we would need to make sure that you're including PCPs in that group to see what their opinion is, if they are providing any of those services that they are just not getting paid for or they are breaking out that global package, which is not always the case, especially in group settings.

And then, I would support what the others have said about that 99024 being a great code to start with, especially in employed, paid physician groups or hospital-owned groups, because they are being paid off of RVUs or production, and that's a great placeholder for those members to get paid.

So, those are just the two things that I would suggest.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of Stephen Lahey.

Stephen Lahey: Yes, hi, I'm from the Society of Thoracic Surgeons. I just want to reiterate the concept that has been mentioned as far as using 99024. We think that's fine because, if you look at the sum total of the other post-op codes — 99211, 99214, and 99215 — it only represents, as far as we know of, approximately 1½ percent of the codes that are filed. So it really is an awful lot of work to try to get to the level of intensity when 98 percent of these codes are going to be 99212 and 99213.

Kathy Bryant: So we've heard a lot about 99024. There are several other issues, I think, in the questions we have here, and we just wondered if anyone had anything to say. For example, one of them is how much consistency is there among patients in terms of the services provided in the pre- and post-operatively? What factors cause the variation in these services or activities? Can someone explain that to us a little bit?

Operator: Our next comment will come from the line of Kimberly Sullivan. Miss Sullivan, your line is open.

Kimberly Sullivan: Hi, my first – my comment is more to the first question that was asked. And one of the questions I have is capturing — or one of the considerations is capturing services that are performed in the hospital that are not performed by the surgeon or the surgeon's surgical group. So, for example, someone who is using a hospital-employed physician assistant or nurse practitioner to do followup services, technically, those things are included in the global and are not billed. But how those things are going to be incorporated, because it wouldn't necessarily be captured at the same time as the — as the information coming from the actual surgeon. And I don't know how to correct for that, but it's just something that needs to be considered.

That's it.

Mark Hartstein: So, this is Mark Hartstein. I want to ask a clarifying question. So, you're talking about the use of physician extenders in the hospital?

Kimberly Sullivan: Correct.

Mark Hartstein: OK. So, are they providing post-operative visits?

Kimberly Sullivan: Yes.

Mark Hartstein: OK. OK, as opposed to where they're employed by the physician and — they are not employed by the physician, they are employed by the hospital?

Kimberly Sullivan: Correct.

Mark Hartstein: OK. And your concern is that these practitioners — the — they are acting as a substitute for the physician in providing a post-operative service that's included in the global period that the hospital's paid for. They are not paid separately?

Kimberly Sullivan: No, the hospital is not paid separately, but it goes to the amount of work that is — that …

Mark Hartstein: Right.

Kimberly Sullivan: …that goes into that global bill, because if you don't incorporate those, you may negate the actual services that the physician is performing.

Mark Hartstein: OK, right. OK.

Kimberly Sullivan: …visits are actually much higher, …

Mark Hartstein: Right, so …

Kimberly Sullivan: … particularly in hospitals.

Mark Hartstein: Correct. So if the same physician extender was providing that visit, let's say, in an office settings, was employed by the physician, that would be part of the global package, not billed separately, either. But in that circumstance, under this data collection, the physician would bill for that service. However, if the physician extender is working for the hospital, it would be no bill at all. So, that's the point you're getting at.

Kimberly Sullivan: Exactly.

Mark Hartstein: OK, thank you.

Kimberly Sullivan: All right, thank you.

Operator: Our next comment will come from the line of Chris Senkowski.
Chris Senkowski: So, I just want to follow up. I think that the other things are going to be — the level of visit is going to be difficult, and I would say that, to your question of consistency, I can give you — just give you an example. I mean, when I have a patient in rural Georgia that lives

2 hours away, their length of stay is going to be a little bit longer because they need more support to get home.

So, I think there's going to be a tremendous amount of variability, not only in system but in pre- and post-operative work and stays, depending upon the region and type of practice. I think that's going to be a tremendous amount of variability.

And to the second — the other point about documentation, if we're trying to get to the level of visit, and currently there's no requirements for documentation, it's going to be a tremendous amount of work to sort of reeducate a group of physicians to then provide that information, because the legislation requires that you find a sample for the level.

So, we have to get to the level, and I think that's going to require a little bit of reeducation of a sample of physicians that again then provide you with their, you know, survey results or their real-time tracking of what they do.

Leah Nguyen: Thank you.

Operator: Currently, we have no further comments in queue.

Determining the Representative Sample for the Claims-Based Data Collection

Leah Nguyen: OK, thank you. Our second topic is "determining the representative sample for the claims-based data collection." Holley, we are ready to hear from our first caller.

Operator: Please stand by for the first caller. Our first comment comes from the line of Matthew Sideman.

Matthew Sideman: Hello, this is Matthew Sideman. I'm a vascular surgeon with the Society of Vascular Surgeons, and I'm also a member of the surgical global workgroup from the RUC committee. I'd like to say thank you for the opportunity to speak and addressing the question about determining the representative sample for the claims-based data collection.

We at SVS and the workgroup think that it's very important to include data not just from large hospital-based practices, but also from medium and small practices, as the practice model will likely differ between these — between these areas. So, we think that the sample needs to be inclusive of all types of practice, not just specialty areas.

We also would like to comment that there is a growing number of registries out there for different specialties and different procedures, and this might be a place to look for some of these samples or some of the representative sample. But each registry is a little different and would really need to be assessed to whether or not they can provide the type of information that needs to be — needs to be gathered.

That was my main comment to this question. Thank you.

Leah Nguyen: Thank you.

Operator: To provide your feedback, please press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please hold while we compile the roster.

And your next comment will come from the line of David Glasser.

David Glasser: Yes, hi, from American Academy of Ophthalmology, again. I agree with the previous comment. It's important to look at both large and small practices, in urban and rural areas, and also to address Kathy's question earlier about variability of the amount of work in the post-op period. The work can vary tremendously.

And maybe that 90-plus percent of the codes determined by the RUC are level II or level III, but there's a huge difference when you look more granularly from one service to another. So, a post-op cataract patient who has sort of a routine post-op visit requires much less work than a post-op glaucoma filtering patient, who may need a manipulation of the surgical site and revision of the surgical site with suture manipulation.

So, I think it's critical to pay attention to the level and not just the number, even though from the 30,000-foot level it looks like most of them are level II and level III. When you get down to the individual practice, it makes a big difference. Thanks.

Leah Nguyen: Thank you.

Operator: Our next comment will come from the line of Maryann Palmeter.

Maryann Palmeter: Hi, thank you. I'm sorry the — apparently, the number 1 on my phone was stuck, and I couldn't get my comments in. Thank you for taking my call. I'm the Director of Physician Billing Compliance for the University of Florida in Jacksonville, Florida, and I have a couple of comments I'd like to make. And I apologize if I'm — might be regressing here. I was trying to get my comments in previously.

One of the concerns I had about the 99024 code, which is an appropriate procedure code, there are some providers that assign a zero dollar charge to that procedure code. And so, that code will not transmit on a claim or could be problematic with claims transmission if there's a zero dollar charge. And the reason we do that is so not to inflate our global surgery packet any further by adding an additional charge to the post-op visit code.

Couple other comments I wanted to make, when we talk about patients, I think patients are very accustomed to the global surgery packet in that if they go in for a surgical procedure, they become very accustomed to having a charge — a physician charge — that encompasses all post-operative care that's related. So, I think there would be a lot of patient education that would have to take place going forward as well if the decision was made to unbundle the global — the post-op visits.

And then lastly, my comment I wanted to talk about, when we talk about data collection, I think it is important to include teaching institutions in that data collection as well because the teaching physician documentation guidelines call for — the teaching physician does not necessarily have to be present for a post-op visit as long as a resident is providing the care, if they don't consider it critical or key.

So, if again, from a data collection perspective, at the end of all of this, if we are unbundling post-operative visits from the global surgery packet, the teaching physician presence will then become required for each and every post-operative visit. So, from a manpower perspective, that's just a comment that I would like thrown into the mix as well.

Thank you for listening to my comments.

Leah Nguyen: Thank you.

Operator: Your next comment will come from the line of Jean Acevedo.

Jean Acevedo: Hi, thank you for allowing me to speak again. So first, I'd like to just reinforce what two of the physicians have said about making sure that small and medium practices are included in any sampling — really very different from large practices and academic medical centers.

And then, the other is, I just don't — I have a hard time even trying to figure out how you could do a representative sample, as opposed to just having it be that everybody reported. There is indeed such variability — the rural population was pointed out by one person speaking. There is also, I think about, like, ESRD patients have this higher risk. I can't imagine that — for the same surgery — that that individual would have the same intensity of visits as a patient who didn't have such a complex comorbidity, and that the level of service and capturing it is — it will probably have more variability.

If physicians realize that it was going to impact their reimbursement as to what they documented compared to what they're documenting today, which I think as I mentioned before is probably more intuitively, you know, nothing wrong with that, as to just what they need clinically as opposed to knowing that somebody was going to look at potentially — or that they needed to represent what they actually did in a numeric fashion because it was going to impact reimbursement.

Thank you again for the opportunity to speak.

Leah Nguyen: Thank you.

Operator: Your next comment will come from the line of Sarah Reed.

Sarah Reed: Thank you so much for taking my call. I've listened to a lot of the comments, and one of the areas, having worked in not only a teaching situation but the private sector, that needs to be considered is, there is no definition of what is considered routine post-operative care.

For one person, it's caring for every problem that the patient has that could possibly be related, and for another, it is caring for the routine part but charging for the complications. And if you have a patient with a lot of comorbidities that they are facing, the surgery itself could be routine, but this could be a brittle diabetic that's also suffering, perhaps, from hypertension. So, all of that is cumulative in how the physician looks to report the care that they're giving the patient, either the extra care that it takes to get the patient ready to go to the operating room or the post-operative care that, in some people's eyes, could be routine, but in others could show the comorbidities.

So, as we look at this, we might need to consider definitions for some of the issues that are topical with regard to what is routine and what is something that's not going to be considered routine as we go to breaking this down.

Thank you. Thanks for taking my call.

Leah Nguyen: Thank you.

Operator: Your next comment will come from the line of Chris Senkowski.

Chris Senkowski: So, again, from the American Oncologist Surgeons. We do not believe that everyone should report. So, this is the "who" question. We think the who question is also strongly related to the what. We think that if you can find a good sample that covers large and small, rural and urban, academic and private settings, then you'll need to choose CPT codes that are widely used and probably fulfills some service screening in terms of volume or dollars.

And that — we think that finding good representative of samples would be important to decrease the burden on everyone to do it. And then we also believe that it may be something that should be rotated in periods from one group to the next to sort of internally validate the process. But we do not feel that every surgeon should be reporting on some new claims-based reporting system for this process.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of Stephen Lahey.

Stephen Lahey: Yes, hi, from the STS again. I just want to strongly agree with Steve Senkowski in that I think the sampling has to be based on something like volume or the frequency of the claims or something like that. It would just be impractical to have everybody reporting.

The other thing I just want to throw out there is, when CPT codes are valued at the RUC, I mean, you really have to understand that CMS has enjoyed a rather significant discount, if you will, for many years, because the codes are formulated based on the typical patient.

And we all know that, many times, all of the comorbidities represent a tremendous amount of increased work by — on the part of the physician. But nevertheless, they are valued based on the typical patient. So that if this were to be dismantled and there were claims based on how often you did see the patient afterwards because you've taken away a lot of this global discount, there would be an enormous increase in people filing claims, seeing patients who are very, very

difficult. And we all know that some of these patients — we don't see them — what is embedded in the value for the CPT code, you know, maybe three or four post-op visits. We may see these patients 10, 12 times. We may see them three or four times in a day.

So I think that all people have to understand that these codes were originally designed for the "typical" patient.

Leah Nguyen: Thank you.

Operator: At this time, there are no further comments.

Determining whether CMS Should Collect Data on All Surgical Services or Sample Services

Leah Nguyen: Thank you. Our third topic is "determining whether CMS should collect data on all surgical services, or which services should be sampled." Holley, we are ready to hear from our first caller.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please hold while we compile the roster.

Your first comment comes from the line of Gregory Przybylski.

Gregory Przybylski: Thank you very much, and an admirable effort at the last name. My name is Dr. Gregory Przybylski. I serve on the Relative Value Update Committee as the American Association of Neurologic Surgeons representative. And thank you for the opportunity to comment.

As Sherry Smith alluded to, our workgroup had met last week and had talked about this issue, and we wanted to formalize our comments on this call. One of the conclusions that the workgroup reached relative to this question is that a sample should be evaluated rather than evaluating all services.

We think that a representative sample would meet the requirements of the legislation, besides the obvious challenge of reviewing all surgical codes with 10- and 90-day globals. Many of these services are of low volume, and that limits the reliability of claims-based data. According to 2014 Medicare utilization, only 108 surgical codes were in the 10-day global period and 152 in the 90-day global period that were performed more than 10,000 times, which is often a threshold we use for obtaining reliable data.

Given this, the collection process should not include all services, as many surgical globals are of low volume, and it would be difficult to get a meaningful sample. We do think that the RUC is in a position to review the Medicare data to determine what those services ought to be that represent both a spectrum of specialties as well as a spectrum of services.

AMA staff has kindly offered to review those by specialty volumes so that we can get services that are performed by more than one specialty. In addition, AMA staff conducted an analysis

that found that only 235 surgical global codes had 100 or more physicians that were performing them. And so, different metrics, we think, need to be used to make sure that you've got reliable data to evaluate.

I think in order to avoid having a system where we have to look for specific claims and go to paper, as opposed to being able to gather this data through claims-based methods and otherwise, I think it will be the only efficient way that we can do this and meet the required legislative requirement. Thanks.

Mark Hartstein: Thanks, Dr. Przybylski, just one question. For – I understand your recommendation to only survey those surgical procedures that have sufficient volume. Do you have a recommendation for those surgical procedures to — what should we do for the surgical procedures that are not surveyed?

Gregory Przybylski: So, one option is to see what the results are for the representative sample. Something similar that the relativity assessment workgroup has done is do a survey using certain thresholds and then, based on what you find, you may expand that survey or decide not to survey any further.

So, there have been examples where the conclusions that were reached suggested that looking at smaller samples really wouldn't give us any added information because we didn't reach the anticipated conclusions. So, it may be a stepwise fashion, and that would be, I think, what I would recommend first.

We did talk about having specialties offer representative procedures from their specialty, but the concern is, naturally, that this may introduce some bias; whereas, if you have a threshold system where the services are simply identified by those that meet a particular threshold, I think that you limit that introduction of bias.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of Tessie Morris.

Tessie Morris: Yes, I want to say that I agree with the previous caller, but I do want to bring up the point of — we are given and monitored under thresholds for overuse for many of the CPT codes or over volume — high volume versus low volume.

Why could we not do a sampling of the high-volume CPT codes — surgical codes — that require various post-operative global periods versus the low — the low usage of CPT codes, no matter what the sector is, so that all can be evaluated by a nonbiased nor by bias? You would definitely have the protocols and establish all of the needs of each of the criterias and most of the criterias that are in the listening session questions that we have been previously discussing. And thanks for listening.

Kathy Bryant: Sure. I just — this is Kathy Bryant. I'd just like to add — to point out the second question that we have in this segment, which for those of you that don't have it in front of you is "are there administrative burdens or advantages associated with reporting claims-based data on a specified subset of service?"

So, some people have expressed difficulty with using HCPCS codes that aren't used for everything. Would the same problem exist within practices if you had to report claims-based data on some surgeries but not on other surgeries, possibly within the same specialties? And we'd just like to hear a little bit about those administrative burdens.

Operator: Your next comment comes from the line of Chris Senkowski.

Chris Senkowski: Well, I think if you tried to assign a level of visit on a claim and you were trying to get a representative sample, maybe you have three or four surgeons from a large group, well they are not going to be able — it would be difficult to see how they'd report it and how you'd select it out to just the Medicare patients through a billing practice that's going to scrub those claims and take them out with no charge associated with it. I think it would be very challenging to do that. So, the burden will be on the creation of a claims-based reporting system that can be picked out of a larger, you know, especially if it's a large institution, how that's going to be actually implemented.

I would also mention that, you know, we looked at — there are 473 10-day globals, of which the average number of post-operative visits is one, and there are — in the 90-day global, there's 3,700, the average — most of them, the average is three.

So, I think that looking at the — some sort of screen, either high volume, high dollar, or something that's performed by a lot of physicians, is the way to sort of winnow that down. And then maybe there is a role to ask the specialist or the specialty society to decide, amongst the family of codes that are screened out, which one would be an anchor code and which one would be related.

And then, I think, once you figure out if the number of visits makes sense compared to what's in the database, then you'll be able to select out those that are — there's a mismatch, to drill down deeper, with a more sophisticated survey that might show up in the level or would certainly help direct you as to the next steps once you validate the numbers. And I realize you have to do both at the same time, but you may take a larger number of codes and look at the claims to see if the numbers line up in terms of visits, and then pick your representative sample from that in terms of a more sophisticated level of service survey.

Leah Nguyen: Thank you.

Operator: And your next comment comes from the line of Barbara Fontaine.

Barbara Fontaine: Hi, I agree with the last caller as far as the burdens that it would put trying to sort out the Medicare patients from the non-Medicare patients. We did PQRS several years ago, and we did claims-based reporting on that. And there were a lot of the HCPCS codes that we used on that that we were forced to send through with a claim, and in order to get them to show on our claim, we put a one-penny charge on it. And then, when those claims came back, we would adjust it off.

So, it was a little bit of a burden to do the adjustments, but it actually worked to get that information to the place that it needed to go. I think our problem with this would be, if someone tried to do a registry, which someone suggested earlier, there are costs involved with registries.

And so, in a sense, you would be penalizing the people who are trying to help you by reporting by insisting that they go through a registry. So I don't think that that's a very viable solution.

I think that's all I have for now, thanks.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of David Glasser.

David Glasser: Thank you, again. You know I'd like to start by strongly supporting Dr. Przybylski's comments about looking at volume within each specialty and picking the high-volume codes where you're more likely to get an accurate data sample.

For the — to answer the question about the low-volume codes, I would say that, you know, the RUC process actually uses a survey methodology that works pretty well. You know, I think there may be a sense that it overestimates the number of post-op visits. But if you look at our cataract code with four post-op visits, a careful analysis showed that the number is really 3.7. That's pretty close. I mean, we don't do .3 or .7 post-op visits.

So, for the lower-volume codes, we maybe don't need to try to do a claims-based sample when we're likely to get bad data simply because the sample size is too small. I'd also like to say that, you know, let's not throw out the idea of a registry. There may be expense involved, but for those specialties that have one and that can use them, that may be a very valuable source of data. Thanks.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of Greg — Gregory Przybylski.

Gregory Przybylski: Thank you, again. To answer the second question that you had, I think there are two aspects to the burden on the provider giving this information. I think the first part of simply having a handful of representative CPT codes that pulls out claims, I think, is not that challenging to do and is not that big an administrative burden.

I think the challenge that comes in trying to determine the level of visits that's associated with that. So, while the 99024 will be identified in the office visits in terms of frequency, there's really not going to be a method other than pulling each individual note, and as other callers have already described, the documentation may or may not be representative of a particular level of visit since it has not been required. But it would really require looking at each individual note in order to be able to at least estimate what that level of visit is, based on what documentation has been provided.

In the inpatient setting, I don't think that most providers, to my knowledge, report the inpatient visits in their billing software. So, when we get to question 4, hopefully, we'll have a solution to that. But I think the big challenge will be in determination of level of visits, and this will be true both inpatient and outpatient.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of Jean Acevedo.

Jean Acevedo: Just to reinforce a couple of points. First of all, I'm in — thoroughly enjoying this give and take and appreciate CMS reaching out to the physician community for input at this early stage. But there — in claims reporting, which I'm probably for, because, as one caller stated, it would seem a shame to penalize physicians to join a registry and have to pay for this.

And of course, CMS could opt to have it be an either/or. But also, just to reinforce that where the variability — right now, practices, many of them, especially the small ones, are still reporting their PQRS measures via claims. And they do that only for Medicare, not for the commercial insurance. So, they are used to, you know, deter — having a system in place that would help them determine when to and when not to report codes. For the caller who made a comment about the zero charts not practicing — I'm sorry, not processing in the claims adjudication system, as a subsequent caller mentioned, because that's the same thing in PQRS, and it was the same thing with the ePrescribing G–codes, where the systems don't allow a claim to pass through to the payer, just assigning a one-cent charge is the — was CMS's solution, actually, way back when and still works. So, just to reinforce some other callers' comments, again. Thank you.

Leah Nguyen: Thank you.

Operator: Currently we have no further comments at this time.

Leah Nguyen: Thank you.

Designing Data Collection Elements To Interface with Existing Infrastructure To Track Followup Visits within the Global Period

Our fourth topic is "potential for designing data collection elements to interface with existing infrastructure used to track followup visits within the global period."

Holley, we are ready to hear from our first caller.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please hold while we compile the roster. Again, please hold while we compile the roster.

Your first comment comes from the line of Gregory Przybylski.

Gregory Przybylski: Thank you, again. As we all know, Medicare keeps track of post-operative length of stay, and we often use that information at the RUC. So on the Part A claims data, we can at least get a sense of the number of visits that would be associated with any particular surgical service that is provided.

As I stated earlier, the challenge will be determining the level of service that's provided, and I think that Sherry Smith's comments to the first question suggested that variability is fairly narrow. And I think that the level of service may not be as important to know, at least at the first

evaluation of this, but rather, is the number of post-operative days consistent with the number of visits that are reported to be able to determine whether at least there is consistency at that level?

From the Part B side, I think the post-operative visits that are done from the office part of the post-operative global, again, simply counting the number of 99024s that are reported, and as other callers have stated and consistent with our multispecialty practice, those are reported with each visit. One can again at least confirm that the number of visits is consistent with what is currently in the database. Thank you.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of Chris Senkowski.

Chris Senkowski: I would support what Dr. Przybylski just said, but I'd also throw in there that we don't — we haven't talked yet about the other expenses that come into post-operative care, such as dressing changes, staple removers, things that are not included in the traditional E/M visit, no matter what the level's posted.

So, that sort of data would be — need to be accessed as well. And two ways that the American College of Surgeons thought about it are, one, the fact that the practice expense is very granular and very well thought out at the RUC process with CMS present is one area to look and validate.

And the other would be to look at facility — facility-owned practices, where the charges and passthroughs could be looked at more carefully in terms of real dollars spent for the practice expense items that are not accounted for in the simple E/M designation. And so, I think that that needs to be strongly considered as well.

Leah Nguyen: Thank you.

Operator: And at this time, there are no further comments.

Leah Nguyen: Thank you.

Using the 5-Percent Withhold until Required Information Is Furnished

Our final topic is "consideration of use of 5-percent withhold until required information is furnished."

Holley, we are ready to hear from our first caller.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please hold while we compile the roster. Again, please hold while we compile the roster.

Again, to come into the queue, press star 1 on your touchtone phone.

Our first comment comes from the line of Chris Senkowski.

Chris Senkowski: So, the college believes that there have been various systems that have offered either initial incentive or initial incentive with a later penalty, and they have gone from various percentages, mostly 5 percent or lower, I believe. And I — we believe that they've been marginally successful and pretty much unsuccessful in trying to encourage people to sign on. You know, we can point to PQRS or Meaningful Use or whatever. But we think that the initial round of this methodology should not — should be voluntary or hold some sort of representative sample that people sign on to and not have a withhold. And the withhold would have to apply to future claims or a future round of reporting should the initial methodology be sound or vetted at first.

And so, we think that this would probably be — end up being a disincentive to even participate, if you're looking for volunteers to provide extra work, especially towards the level of visit is the hardest part to figure out in this whole process.

Leah Nguyen: Thank you.

Operator: And your next question — or comment will come from the line of Tammy Lofton. Tammy, your line is open. That comment has been withdrawn.

Your next comment will come from the line of Margie Thomas. And Margie's line has been withdrawn. Your next comment will come from the line of Maryann Palmeter.

Maryann Palmeter: Hi, thank you, again, for taking my comment on this particular question. I guess I'm a firm believer, too, in positive reinforcement versus negative reinforcement. I think that withhold amounts tend to really interrupt operational efficiency. I also think that there tends to be more of a bias when it comes to large practices, multispecialty practices being subject to that. So, where the organization is much more complex and complicated and, I think, sometimes unfortunately, submission of records that are requested sometimes take longer. We may not be able to comply within certain timeframe constraints. So, I just think that large practices — it could be problematic or biased for large practices. So, that's just something that I wanted to throw out there.

Leah Nguyen: Thank you.

Operator: Your next comment will come from the line of David Glasser.

David Glasser: Thank you. The thought of a 5-percent withhold brings to mind the somewhat cynical saw "the beatings will continue until morale improves." I think we have pretty good evidence of decreasing participation in some of the other programs, as the first commenter mentioned.

But I think even more importantly is the last caller's comment that this is going to introduce bias in — by creating a selection bias for those who can versus can't participate and stratify it based on who's willing to accept versus not accept the withhold. So, I think it's going to give you less reliable data if you use a withhold. Thanks.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of Clemens Schirmer.

Clemens Schirmer: Thank you for taking my comments. I would want to say that, conceptually it's difficult to introduce a global withhold if you're planning on just sampling a specific group of, if you will, practices or providers, because unless you're planning on sampling everyone, then a 5-percent punitive measure would disincentivize a specific group from signing up to a targeted across-the-board sample of people.

So, I think, conceptually, this is, you know, going back to the previous questions and comments, a little bit at odds with, I guess, the plans to potentially just sample a subgroup of all providers in the U.S. Thank you.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of Jean Acevedo.

Jean Acevedo: First, just this wasn't why I was chiming in again, but extremely interesting comment, the last one, about the unlevel playing field if it's reprent — "representative" sample as opposed to all surgeons.

But I would love to comment on the third bullet in this: How would we link the post-operative visits or activities reporting to the original surgery, which is a great question because the patient might have had surgery A, with subsequent more extensive surgery 3 weeks later, or need to have a return visit to the OR, and if we're just using 99024 with or without modifiers to denote the level of service, how do you know which surgical procedure this was actually for? So I wonder if — so I had two thoughts just sitting here. One would be that the date of service for the post-op visit on the claims, if its claims reporting, would be the same date of the surgery. And I know that CMS can process things that way. I think about chronic care management, with the date of service has nothing to do with the date of the actual services that were rendered, etc., or knowing that for a physician, to get paid for subsequent surgery, he or she must append a modifier 58, 79, something if that modifier was then appended to the code so that it would link it to the subsequent surgery.

Just a couple of thoughts on that bullet.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of Stephen Lahey.

Stephen Lahey: Yes, I think that was a very, very interesting comment. But I wanted to go back to the 5-percent withhold. And you're basically asking, is this enough pain? And I think it's really an unfair question. Although I'm personally in a full-time academic university setting, I feel very badly for people in a smaller group practice where a 5-percent withhold is going to be a very, very big deal to that smaller group.

Whereas somebody like myself is somewhat insulated from that 5 percent. In a sense, it's sort of like playing with the house chips, and I'm once removed from the pain of that 5 percent. So, I think it's a bit unfair. I think, as somebody has previously said, it's a bias in favor of the people

in the large academic groups that don't — they're not going to really feel this pain as much, and so they may not be as willing to participate in it.

Leah Nguyen: Thank you.

Operator: Your next comment will come from the line of Matthew Sideman. Matthew, your line is open. Matthew's question has been withdrawn. Your next comment will come from the line of Chris Senkowski.

Chris Senkowski: Just to reiterate that, I agree that the physicians that would be most hurt by this would be rural practicing physicians who really rely on Medicare patients and the fees they collect from taking care of those people.

I think that if — given the timeline is so short and we're looking at January 2017, and you're probably looking at maybe not so many volunteers to do this but maybe mandating some groups do this, that if we are going to look at some sort of withhold, that the education efforts to get that information out there need to start very early. So, I think the ACS and, I'm sure, the AMA will be interested to know if this does become part of the process that educating people on the front end is going to be very important.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of Joyce Nurenberg.

Joyce Nurenberg: Hi, this is Joyce Nurenberg from the Medical College of Wisconsin. Taking off from that — the last commenter — you know education, I think, is important, and of course, you know, we know that, you know, the valuation — these global surgery periods has to be evaluated. So, I'm just wondering if it could be communicated in a common way to say, "Hey, we're looking at these services and we've asked, you know, groups to participate. We've now had participation of X amount," so that people can see what the other groups are commenting. So maybe you're 20 percent there, you're 30 percent there, and so if people realize that we're doing this together, that maybe people will contribute without having the 5-percent withhold because, you know, this needs to be — the decision needs to be with more data and so it's all informed.

So, I think that in itself is probably going to be somewhat of a draw to contribute. The other — the other thing, I think, makes a difference is, I think I heard that — and I – we'd be consistent with this, is that, on the inpatient side, you know, we're not abstracting the 99024 or any other code that might be part of the global package as part of that routine care.

And so, if there was a way, an easier way, to get that information, like, if we could be notified that you're going to be asking for data on these codes for this period of time, that then we could potentially change a process to say, "OK. We're going to have to send in this data." And do it at that point instead of perhaps retroactively and then having to recode the items for level of service and all of that. So that would be another way of — depending on how easily the information was going to get to — that we could get to it. I think there would be higher voluntary participation.

And then, the other point I want to — you know, the other point of this is that, that whole zero-dollar point, we never had to do that, because by the time we had to do that, we were already having to report as a group, and — but I know from a lot of groups that that was a big problem. I heard somebody on the phone say that they had to then, afterwards, go back and adjust all those, you know, penny prices. And again, in an academic organization, it's like a huge — a huge impact of having to then go back and write all of that off. You know, the testing that has to occur to even send that penny. So, you know, I just wonder why either the carriers can't accept the zero charge, you know, or something. But it just has to be an easier process for participation. And I think I've utilized my 3 minutes and more.

Leah Nguyen: Thank you.

Operator: Your next comment will come from the line of Gregory Przybylski.

Gregory Przybylski: Hello, and thank you again. It seems that the purpose of this activity is to confirm whether the reported inputs accurately represent what is happening in the global service package, and if it's not happening, when is that not happening, and why not. In order to get at that information, I think you're going to need a lot of cooperation from physicians and others to be able to get down to that answer.

And as multiple callers have reinforced, if we don't get a broad sample representation, I don't think we'll get at that answer. A 5-percent withhold is exceedingly difficult to absorb by folks who are actually in — to participate — are going to have to take on an increasing financial burden in order to provide this data, whereas some of it can be presented via automated systems. If you want to get down to the level of visits, as has been already discussed, that's going to require a fair amount of manual work that will be FTEs.

And if you want to encourage physician participation, a 5-percent withhold is not likely to be that method, and, at best, you may get the bigger practices that may be able to, for example, at a university setting, absorb some of that cost in order to provide that information, and then the data will not be as reliable.

So I think the 5-percent withhold is not an ideal method. And certainly, to account for the cost that's required to provide down to the level of service would be the preferred way to try to encourage participation. And then, in terms of the third question about linking post-operative visits to the original surgery, you do have to keep in mind that many procedures are coded with other procedures as well. And so, if a — let's say, we used a threshold method to identify the sampled service, the actual levels of service that are provided as well as the number of visits may also be influenced by the additional codes that are reported with it. As we know, there are add-on codes that exist, but they do not contain pre- and post-operative visits. However, they may influence the length of stay in the hospital. So, you do need to keep that in mind, and a more granular inspection of the chosen codes may be required after the first run of the data.

Thank you.

Operator: And your next comment will come from the line of Barbie Hays.

Barbie Hays: Hi, Barbie Hays again, from the American Academy of Family Physicians. Just to utilize technology that we already have, just – on the HCFA 1500 form, lines 14 and/or 15 already are in date format. Line 14 is, for example, last menstrual period or pregnancy, but it also says for current illness or injury. So, that could be a possibility, as far as that third bullet, as a way to record those dates because most EMRs would have that capability, that crosswalk, and that would be one way to encourage that date to be reported.

Leah Nguyen: Thank you.

Operator: Your next comment will come from the line of Gayle Englund.

Gayle Englund: Hello, this is Gayle Englund from the University of Minnesota Physicians. Just to comment about a possibility other than using claim-based data. We're all very familiar with CERT requests, where someone has to analyze the chart, pull records, compute required data.

Just a thought that, if claims-based, depending on the volume and the universe of the size of the sample, perhaps levels of service and who actually performed a post-op visit, whether it was a resident acting alone or a hospital, NP, PA could be tabulated. Just a thought. Thank you.

Leah Nguyen: Thank you.

Operator: And your next comment will come from the line of Maryann Palmeter.

Maryann Palmeter: Hi, I appreciate the last caller's suggestion, and I wanted to add, although we have the CERT contractors requesting medical record documentation, I do believe a previous caller also mentioned that documentation oftentimes is not as detailed as it may be if we were separately billing for a post-operative visit.

So, if we have post-operative visits that are bundled into the reimbursement for the global surgery packet, the physician or the provider may not be as likely to touch upon every required element that's necessary in the documentation to support a particular level. So, if a medical record chart was requested, the documentation may not necessarily stand up to a particular level of service.

And I think, ultimately or coincidentally, I think, the same would occur with the levels of service billed on the claim form if we were submitting a level of service, a dummy code per se that was assigned this particular level of service, I think if providers realized that, I think you're going to see some changes in documentation behavior as well. So, the request for a certain way to bill a claim can certainly have an impact on the documentation behavior.

So whether you're getting an accurate picture or one that's kind of, then, behavior that's changed as a result of what Medicare or CMS is asking for may create a problem. Thank you.

Leah Nguyen: Thank you.

Operator: And currently we have no further comments in queue.

Further Comments

Leah Nguyen: Thank you, Holley. We would like to see if anyone has comments on any of the five questions. If they want to go ahead and get back into the queue by pressing star 1, we can take those comments.

Operator: Again, to provide feedback on any of our topics from today, please press star 1 on your telephone keypad. Again, that's star 1 to come into the queue.

Kathy Bryant: And this is – again, I just wanted to mention a couple of things that we haven't heard a lot about. We heard a lot about that the 5-percent withhold was not a good way to ensure compliance with any requirements that we might impose. Do people have suggestions about a better way of assuring that the physicians that are selected to report do report and report accurately?

And then we didn't hear a lot about collecting data on practice expense. So, if people have ideas on either of those, this would be a good time to share those as well.

Leah Nguyen: Thank you.

Operator: Again, to queue up, it's star 1 on your telephone keypad. OK, we have a comment from the line of David Glasser.

David Glasser: Well, I think Greg Przybylski mentioned this before on practice expenses, you know, I think the RUC has a very well thought out and detailed method for determining practice expense. And if that can be applied to groups to collect data, I think that would be pretty accurate. As far as encouraging participation, you know, I think if you go for volunteers, you'll get participation, but you won't necessarily get all of the different sample that you want.

You're going to need to reach out, I think, to some of the smaller groups and the rural groups. It's going to be easy to get data from the big groups, and it's going to be tougher to get it from the smaller groups. And penalizing them is not going to help. But reaching out to them and giving them some incentive to participate might actually work. Thanks.

Leah Nguyen: Thank you.

Operator: Your next comment will come from the line of Sherry Smith.

Sherry Smith: Yes, I was just going to speak to the practice expense issue. I think that the RUC concluded that it would be almost impossible, not feasible at all, to do any sort of claims collection on the additional practice costs that go into surgical post-operative visits, for example, more expensive lights or use of scopes in some cases, as well as supplies that relate to the recovery after surgery.

So, the RUC discussed that you would collect that information as well, you know, potentially other information that might not be quotable, like care coordination, time, and so forth, on the part of the physician and/or their staff in preparing a patient for surgery. Because I notice you brought preservice time into the questions for today as well to, you know, care coordination

following the hospitalization that could most feasibly be done either surveying the selected physicians, or perhaps having a portal where you would have the physician or their staff go in and itemize what you know from a list of preexisting supplies or equipment that would be made available to them, like a checklist or something, that those are things that are typically used in their office or were used for that particular surgical case. Thanks.

Operator: And your next comment will come from the line of Chris Senkowski.

Chris Senkowski: So, I think that if — if you look at the way that this gets rolled out might be best — might be better than an incentive. And what I mean is, if you look at the claims-based data and come up with a number of visits or look at reliable sources for 99204 and come up with the numbers, and then, you know, relate this to various specialties and their codes and then, you know, have that internal check with what's in the payment database — the RUC database — then you'll be rolling it out to the physicians to say, now we need you to show us that these levels are, in fact, true. And so now, there may be some that the RUC database has fewer visits than what's true in the claims database. There may be some that are the opposite of that. And that would be the incentive to say, "Now we need you to participate because we need you to show us that that's happening, yes or no."

And that incentive to then provide that extra work for the level, I think, will be incentive enough because you'll have some codes that are mismatched.

Leah Nguyen: Thank you.

Operator: And currently, we have one comment that has come into queue, the line of Donna Kinney.

Donna Kinney: Hi, this is Donna Kinney of Texas Medical Association. I just wanted to reiterate — I've put this in written comments before — if you need physicians to provide you with additional information and data, clearly the way to incentivize them to do that is to compensate them in some way for that additional work. That's all.

Leah Nguyen: Thank you.

Operator: And currently no further comments.

Additional Information

Leah Nguyen: Thank you. If you did not have the opportunity to provide your comments, you can email them to the address listed on slide 10 of the presentation. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

Again, my name is Leah Nguyen. I would like to thank our subject matter experts and also thank you for participating in today's MLN Connects listening session on Collecting Data on Global Surgery as Required by MACRA.

Operator: This concludes today's call. Presenters, please hold.

-END-


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