MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Data Collection on Resources Used in Furnishing Global Services Information Session
MLN Connects National Provider Call
Moderator: Leah Nguyen
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2:00 pm ET

Contents

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

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

Announcements and Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects Information Session on Data Collection and Resources Used in Furnishing Global Services. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, learn about the proposed data collection activities on resources used in furnishing global services outlined in the calendar year 2017 Physician Fee Scheduled proposed rule.

Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015—or MACRA—requires CMS to develop and implement a process to gather and analyze the necessary data on pre- and post-operative visits and other services furnished during global surgical periods other than the surgical procedure itself.

This call will not include a question and answer session. Before we get started, I have a couple of announcements. You should have received a link to the presentation for today's call in previous registration emails.

If you've not already done so, you may view or download the presentation from the following URL, go.cms.gov/npc. Again that URL is go.cms.gov/npc. At the left side of the webpage, select National Provider Calls and Events. Then select the August 11th 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. Registrants will receive an email when these materials are available.

At this time I would like to introduce our first presenter, Kathy Bryant, Technical Advisor to the Hospital and Ambulatory Policy Group at CMS.

Presentation

Kathy Bryant: Thank you, Leah, and welcome to everyone on the call. Today's presentation is designed to give you the highlights of a proposal that CMS recently made in the calendar year 2017 physician fee schedule proposed rule. Your slides have the link for where you can get that proposal, which begins on page 46191 of that rule.

We – this is a proposal, and so we are accepting comments on this proposal. And I do want to encourage you all to take advantage of the opportunities that we have for you to provide feedback on this rule. This is a new area for CMS, to some extent, and we really would like to hear from you about that.

A couple of notes about providing feedback. The comment period closes at 5:00 pm on September 6th. And in order to submit official comments at www.regulations.gov/ or mailing them to us, you need to follow the instructions in the proposed rule.

In addition, because we want to provide an extra opportunity for feedback on this proposed rule, we are also going to be conducting a town hall on our August 25th. This is an additional opportunity for stakeholders to share their feedback on the proposal.

Again, we encourage you to also submit comments through the normal comment process.

The – for the town hall there will be two segments. One segment, an in-person segment, will be held here at CMS and it will be on the morning of August 25th from 10:30 to 12:00. That will also be available for you to listen via a phone line. And that information will be available when you register. You do have to, when you register, indicate as to whether or not you intend on making a presentation.

And then in the afternoon, those who would like to make a presentation but who can't be here at CMS in person will have that opportunity via a virtual present – I'm sorry, a virtual presentation. And that will begin at 1:00 to 2:30. If you want to participate in these sessions, please register. Again, the information on how to register is included in your slides.

And with that I would like to turn it over to Chava Sheffield, who is going to review some of the background on this proposal. Chava.

Global Packages

Chava Sheffield: Thank you, Kathy. Medicare pays for many services, such as surgery, using a global package. Global surgical packages include post-operative visits, pre-operative visits, and other bundled services falling within one of three time periods. For zero day global services, this includes only the day of service. For 10-day global services, this also includes up to 10 days following the service. And for 90 day global services, this includes the day before the service through 90 days after the service.

In addition to the intra operative services and those that occur immediately before and after the procedure, global packages also include the surgeon's services related to pre-op visits, complications following surgery, post-op visits, and post-surgical pain management.

Other items that are also included in the global package are supplies and miscellaneous services, such as dressing changes, removal of sutures and staples and changes and removal of tracheostomy tubes, which are also included in most cases.

While CMS supports bundled payments as a mechanism to incentivize high-quality efficient care, we have expressed concern that the global packages function differently than other bundled payments for several reasons. CMS does not use actual service data to update the rate.

Concerns with Global Packages

One of our main concerns is the lack of data to regularly update the packages, as is done with the other bundled payment systems using cost reports. The level of the post-operative visits is of critical importance in collecting actual service data to improve the accuracy of the global packages.

Typical services are based on assumptions. We have noted that valuation is based on assumptions that have been, at least in part, refuted by available data, such as OIG reports. Variations between the assumed typical case and the actual typical case cause larger distortions in payments for global packages given that they affect a greater number of service units.

Rates for services with global packages are not regularly adjusted. We've also noted that that the concept of global packages was created several decades ago when surgical followup was more homogenous. Significant changes have occurred with the types of service, the healthcare delivery system, business arrangements, and beneficiary means. However, the basic structure of the global package is the same.

Finally, global payment policies could affect what services are actually furnished. In the CY 2015 Physician Fee Schedule, CMS finalized the policy transforming all 10-day and 90-day global periods to zero-day global periods. Under this policy, practitioners would have billed separately for pre-op and post-op visits. As we indicated the rule, separate billing would increase payment accuracy and avoid potentially duplicative or unwarranted payments. It would also facilitate the availability of more accurate data for new payment models and quality research.

In addition, it would also eliminate some of the disparities that are present between separately furnished E&Ms and E&Ms that are furnished as part of the post-op period.

And I am going to turn it back to Leah.

Keypad Polling

Leah Nguyen: Thank you, Chava. At this time we will pause for a few minutes to complete keypad polling. Ronni, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter number of participants that are currently listening in.

If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Leah Nguyen.

Presentation Continued

Leah Nguyen: Thank you, Ronni. I would like to introduce our final presenter, Andrew Mulcahy, from RAND.

CMS Proposed Data Collection

Andrew Mulcahy: Thank you. I'll go over some of the details in the proposed rule on the three-pronged approach to data collection. This first slide just lists out the three different avenues for data collections, and then I'll go through each of them in a little more detail.

The first is claims-based reporting to get at the number and level of pre-operative and post-operative visits.

And then because claims are limited in what they can describe beyond the number and level of discrete visits, the second avenue for data collection is a survey and a representative sample of practitioners about the activities involved in and the resources used in providing pre-operative and post-operative visits and other care during the – during global periods.

And then, finally, the third avenue is a more in-depth study, including direct observation in a small number of sites, including some practices participating in ACOs.

So I'll describe that claims based reporting avenue in more detail. CMS asked RAND to develop a set of potential no-pay codes for use in reporting post-operative visits. The URL on this slide links to the RAND report on this – on this question. I think it's – that PDF is also available through the RAND website. No separate payment would be made for reporting these codes.

The table on the next slide outlines the set of codes that are detailed in the RAND report. There are a set of codes, three in the inpatient setting, that would capture

inpatient visits that vary in terms of their intensity: typical, complex, and critical illness, that are reported per each 10 minutes.

The next set of three is in-office or other outpatient setting. One of these codes is for typical. Another is for complex visits, also both reported for 10 minutes. And the third is for visits furnished by clinical staff, also reported for 10 minutes.

And the last two codes are for phone or Internet visits provided by physicians, NPPs, per 10 minutes or by other clinical staff per 10 minutes. And there are some important caveats and other details from the proposed rule listed underneath that table.
For instance, these codes pertain only to service included in global packages. The clinical staff visits apply only when the patient is not seen by the physician or other practitioner during the same visit. And then the phone and Internet services are reported only if they are not furnished the day before the day of or the day after a visit.

So this set of codes that are outlined in the proposed rule will follow some familiar coding conventions. First, they differentiate between different types of service, including inpatient, outpatient, and remote. They also differentiate between different types of providers, including physicians in an office setting and clinical staff in an office setting. They distinguish between different levels of complexities: typical, complex, and critical care for inpatient visits and then typical and complex for office. And they also are reported in increments of 10 minutes.

The proposed rule proposes to require reporting by any practitioner furnishing a service with a 10- or 90-day global period in order to achieve a set of goals that are outlined in the proposed rule, including to ensure data is collected across specialties, geographic location and practice size, across different practice models, different levels of patient acuity, and different practice patterns in order to collect data on pre- and post-operative visits for relatively low volume procedures and to use a uniform approach for notifying practitioners in collecting data.

As I noted before, the proposed rule highlights how claims-based reporting can capture the number and level of visits, but that understanding the full range of activities related to global services will require additional information. And to that end, the rule also outlines the second main avenue for data collection through our provider survey that will collect information on the activities, time, and resources involved in furnishing pre-operative and post-operatives visits and other services in global periods.

I think it's important to note that a representative sample is essential to represent the scope of services. I'll discuss that sampling approach in a minute. The proposed rule has some details on that approach.

RAND partnered with NORC to field – to design and field the survey. The proposed rule describes features of the survey and approach, including the sample size of

approximately 5,000 practitioners, and that each of those responding practitioners will report on approximately 20 discrete visits during a fixed reporting period of approximately 2 weeks.

So a representative sample across different specialties and other characteristics of physicians is important for this part of the data collection effort. The sample will include practitioners that furnished in prior periods above a minimum threshold of procedure volume. And that – the purpose of that is to ensure that the respondents will be able to draw on enough pre-operative and post-operative visits during the reporting periods.

The work related to the sampling plan for this data collection effort is designed to ensure that CMS will collect adequate reliable data on a full range of activities, including care following a wide range of procedures, and a large enough volume to describe difference between specialties, clinical setting, and other factors.

The survey data will complement the claims-based data collection approach.
In particular, the visit level – survey data will allow us to explore differences in the kinds of activities and other characteristics of care across different procedures, different practitioner specialties, geography, and other factors.

And the final third avenue for data collection outlined in the proposed rule is a set of direct observation activities. This data collection also supplements the survey and the claims data collection. That the direct observation component of data collection is proposed to takes place in a small number of sites with the goal of informing survey designs—design through semi-structured interviews to validate survey results through direct observation of post-operative and pre-operative visits. And to collect additional information that's not amenable to collection either through either the claims-based collection effort or through survey-based reporting.

So at this point I'll turn it over – back over to Kathy Bryant.

How to Comment on the Proposal

Kathy Bryant: Thank you, Andrew. Again, I hope this has given you a sense of the types of things that are included in this proposed rule and to help you in preparing comments if you are going to submit them.

Again, I want to emphasize we are interested in comments on the entire proposal that Andrew has described. In addition, we are particularly interested in comments on all aspects of the G-codes that we have proposed. Since these are new codes, there may be many aspects that you wish to comment on, whether they are adequate, whether others are needed, whether there is a simpler approach.

We also specifically sought comment in the rule on the potential use of CPT Code 99024 to capture the statutorily required information, which, as we noted, is both the number and the level of the visit. So we discussed some ways in the proposed rule that we might be able to use that for level.

And, also, on any special provisions that might be needed for teaching physicians, again keeping in mind that we're collecting this data upon which to base payments and, if in the teaching situation, someone is providing services that may not be – that we would not be capturing, would that be showing us lower resources than are actually used? And there is a section in the proposed rule on teaching physicians specifically.

Again, I remind you that you can submit your comments in writing through our – through the normal notice and comment rule making process, and, in addition, you can participate in our town halls. Just a reminder, of course, you do need to be registered for those. And, again, security requirements and otherwise require us to have that registration in advance.

So, again, I hope you will be commenting on our proposal, and thank you for listening today. And now I want to turn it back over to Leah.

Additional Information

Leah Nguyen: Thank you, Kathy. 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 presenters, and also thank you for participating in today's MLN Connects information session on Data Collection on Resources Used in Furnishing Global Services. Have a great day everyone.

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

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