ACS AMERICAN COLLEGE OF SURGEONS

April 23, 2025

Paul B. Masi, M.P.P.
Executive Director
Medicare Payment Advisory Commission
425 I Street NW
Suite 701
Washington, DC 20001

RE: MedPAC Consideration of Global Surgical Payments in the Medicare Physician Fee Schedule

Dear Executive Director Masi:

On behalf of the over 90,000 members of the American College of Surgeons (ACS), we are providing additional background as the Medicare Payment Advisory Commission (MedPAC) considers physician payment reform, particularly regarding global surgical payments as required under federal statute. The ACS is a scientific and educational association of surgeons founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. We believe that sound payment policies are essential to ensuring beneficiary access to quality care and maintaining a robust supply of high quality surgeons.

The ACS shares MedPAC's goal of ensuring accurate Medicare payments to physicians through the Resource Based Relative Value System (RBRVS). This includes global surgical payments and other items and services covered under the Medicare Physician Fee Schedule (PFS). Having participated in the initial valuation of services under the RBRVS and the ongoing process of revaluation through the American Medical Association's Relative Value System (RVS) Update Committee (AMA RUC) and PFS rulemaking, we believe it is important to revisit the policy goals that led to the creation of global surgical payments, including their history and evolution over time. We also believe it is critical to maintain global surgical payments and look forward to providing continued input on how to update values for global surgical payments using data and methodologies that are sound, rational, and geared toward maintaining the integrity of a system that is intended to value services relative to each other.

History of the Global Surgery Payment Policy

In considering global surgical payments going forward, it is useful to review the history of global surgical payments and policy discussions as they were created

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and maintained over the last 38 years. Patients and payors have long appreciated the efficiency of a single bill for a surgeon's procedural care – a global surgical payment – predating the RBRVS. Under the predecessor usual, customary, and reasonable (UCR) payment policy, billing practices varied.

The extent to which a global surgical charge included pre-operative and post-operative visits was often unclear, leading to efforts for more precision on what was included in a global surgical package.[1] Even though Medicare carriers at that time utilized the concept of global surgical packages under UCR, their approaches lacked consistency.[2]

As early as *The 1987 Physicians' Practice Follow-up Survey*, experts suggested "…that measures of physician effort should take into account the time spent providing pre- and post-operative care."[3] During this pre-RBRVS era, hospital reimbursements transitioned to a prospective payment system, creating "bundled payments" for hospitals, including for surgeries that were billed using global surgical charges.[4] Aligning hospital and physician payment structures was seen as essential.

Leading up to RBRVS, policy approaches continued to support global payment for surgical procedures. In its 1989 report to Congress, the Physician Payment Review Commission (PPRC) recommended that lawmakers "rationalize the pattern of payments to physicians by Medicare and to slow the rate of increase in program costs so that they are affordable to Medicare beneficiaries and taxpayers,"[5] while emphasizing "concerns about the erosion of financial protection and access to quality medical care for Medicare beneficiaries, inequitable payment rates for physicians, and excessive administrative complexity under current Medicare policies."[6]

Ultimately, the PPRC's "consensus panel made up of surgeons and carrier representatives," recommended "a policy to determine which services associated with an operation should be

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[1] *See,* Rosenbach, M. Phd., et al. Health Economics Research, Inc. June 30, 1988. *The 1987 Physicians' Practice Follow-up Survey*, Executive Summary, p. 3-1; for the average number of post-op visits found for selected procedures documented through the 1987 Physicians' Practice Follow-up Survey, *See,* Table 3-1, *Distribution of Post-Hospital Office Visits for Selected Surgical Procedures*.

[2] "*However, there are significant variations among carriers as to what periods constitute preoperative and post-operative care and what specific services are included in these periods. For example, in a recent carrier survey done by HCFA, 53 percent of carriers included preoperative care in the global surgical fee. The range of days in this preoperative period was from 2 to 5 days prior to surgery. While 100 percent of carriers include post-operative care in most global surgical fees, the number of days, in post-operative care varies by procedure. The number of days included in post-operative care ranged from 0 to 270 days after surgery. Studies done by other groups such as the PPRC and the Center for Health Economics and Research (CHER) similarly demonstrate the lack of a national uniform global surgery policy among Medicare carriers*." 55 Fed. Reg. 36200 (September 4, 1990). *See also*, 56 Fed. Reg. 25829 (June 5, 1991).

[3] Rosenbach, M. Phd., et al., Health Economics Research, Inc. June 30, 1988. *The 1987 Physicians' Practice Follow-up Survey*, Executive Summary, p. 1-1 ("*This research was supported by HHS Contract No. 100-86-0023 cosponsored by the Assistant Secretary for Planning and Evaluation and Health Care Financing Administration, Sharman Stephens and Deborah Williams, government project officers. The work was performed under subcontract to NORC. The views and opinions expressed in this report are the subcontractor's and no endorsement by ASPE, HCFA, or DHHS is intended or should be inferred*.")

[4] Rosenbach, M. Phd., et al., Health Economics Research, Inc. June 30, 1988. *The 1987 Physicians' Practice Follow-up Survey*, Executive Summary, p. 3-5.

[5] Lee, P. MD, Ginsburg, P PhD, LeRoy, L. PhD, Hammons, G. MD. April 28, 1989. *The Physician Payment Review Commission Report to Congress.* JAMA. 261: 2382.

[6] Lee, P. MD, Ginsburg, P PhD, LeRoy, L. PhD, Hammons, G. MD. April 28, 1989. *The Physician Payment Review Commission Report to Congress.* JAMA. 261: 2382.

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included in the global payment for surgery and which ones should be paid separately,"[7] which limited beneficiary financial liability and administrative burden on the Medicare program.

From this recommendation, the *Omnibus Budget Reconciliation Act of 1989* (*OBRA* of 1989) mandated that the new RBRVS include global surgical packages:

> *Determination of Relative Values for Physicians' Services*[8]*.—*
> *(1) Division of physicians' services into components.—In this section, with respect to a physicians' service:*
> *(A) Work component defined.—The term "work component" means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service.* ***Such portion shall****—*
> *(i) include activities before and after direct patient contact, and*
> *(ii)* ***be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services****.*

(Emphasis added.) This section of *OBRA of 1989*, which mandates global payment for surgical services, remains in statute today.

As the Centers for Medicare & Medicaid Services (CMS) (then the Health Care Financing Administration (HCFA)) prepared to implement the RBRVS, it considered the value of global surgical payments and the drawbacks of treating post-operative visits separately. In its 1990 pre-rulemaking notice, the Agency acknowledged that the new payment system would significantly reduce payments for surgical services:

> *We believe that the lowered payments for surgical services under the RBRVS could provide an incentive for surgeons to "unbundle" heretofore global services and bill separately for some pre- and post-operative services. 'Unbundling' is the process whereby physicians fragment a procedure, such as a total hysterectomy, into its component parts, billing separately as if each component were done as a separate surgical procedure. Unbundling can also occur when surgeons bill separately for visits related to the surgical procedure. This can result in charges that are much higher than if the total procedure was correctly described and billed. "Unbundling" is not a new concept, and all third party payors, private insurers as well as Medicare, are concerned about it. The increased value of visits and consultations could add to the incentive to "unbundle." This could provide a means for surgeons to offset payment reductions for surgery expected under' the RVS based fee schedule.*

[7] Lee, P. MD, Ginsburg, P PhD, LeRoy, L. PhD, Hammons, G. MD. April 28, 1989. *The Physician Payment Review Commission Report to Congress.* JAMA. 261: 2382; *See also,* Health Care Financing Administration (HCFA) summary of PPRC recommendations at 55 Fed. Reg 36202 (September 4, 1990).

[8] 42 U.S.C. 1395w–4(c).

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> *For all these reasons - budget neutrality, payment equity, and safeguarding against unbundling - we are proposing the following uniform national definition of global surgical services. This policy would apply in all settings. Although there is considerable existing variation among carriers and no national existing "norm," we believe that our proposal reflects what exists at many carriers and, to a certain extent, the way that physicians already bill.*[9]

HCFA also stated, "… a global surgery policy should reflect the total work required for the surgeon to complete the service once the decision for surgery is made."[10] To operationalize this, HCFA said that, "[t]he work, practice expense, and malpractice [relative value units (RVUs)] would be added to arrive at the total RVUs for a global surgical service,"[11] thus ensuring the full spectrum of typical services associated with a procedure were included in the RVUs.

Special Focus on Post-Operative Visits

Global surgical packages today include payment for the surgery itself, as well as pre-operative and post-operative services. We wish to highlight the differences in the post-operative visits included in global surgical packages from standalone office visits. While the work involved is equivalent to the office and outpatient evaluation and management (E/M) services, there are significant differences in practice expense (PE) and professional liability insurance (PLI). Examples of additional PE, as listed in the Medicare Claims Processing Manual,[12] include:

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

The PLI RVUs in 10- and 90-day global procedure codes reflect the PLI of the surgeons performing these procedures. In contrast, the PLI in discrete E/M services includes providers with lower PLI rates. Therefore, when a surgeon performs a post-operative E/M service for a 0-day global procedure, they cannot fully recoup their total PLI costs because the post-operative E/M PLI is diluted with lower PLI rates.

Post-operative visits included in the valuation of global codes are, by definition, related to the underlying surgery. If they were not related to the surgery, they would be separately billable E/M visits submitted with Modifier-24 (*unrelated evaluation and management service by the same physician or other qualified health care professional during a post-operative period*). As it was

[9] 55 Fed. Reg. 36200 (September 4, 1990); *See also*, 56 Fed. Reg. 700 (January 8, 1991) and 56 Fed. Reg. 59590 (November 25, 1991).
[10] 56 Red. Reg. 25830 (June 5, 1991).
[11] 56 Fed. Reg. 25831 (June 5, 1991).
[12] Medicare Claims Processing Manual, *Chapter 12 - Physicians/Nonphysician Practitioners*, 40.1 "Components of a Global Surgical Package"

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at the implementation of the RBRVS, it is good policy for Medicare to include *all* care related to the underlying procedure in the global surgical package, including post-operative care. This ensures that patients are not subject to financial liability for necessary follow-up care and avoids unnecessary administrative claims processing costs.

HCFA's statement at the outset of the RBRVS solidified the thinking behind the inclusion of post-operative visits in global surgery and this rationale still holds today:

> *We agree that not all patients require the same amount of post-operative care. While some do require more than the usual amount of care, others require less than the usual amount, and the amount of post-operative care will thus average out over time and patient population. The global surgery RVUs are for the typical patient, and thus are intended to cover both easy and difficult cases . . .*[13]

History of Payment Redistributions in Global Surgery

When the RBRVS was developed, physician services were not intended to reflect resource use, time, or practice costs. However, the shift to these factors caused an immediate re-balancing of payments among specialties. Early simulations indicated that "program payments for surgical services would in the aggregate be about 16 percent less under the fee schedule, while payments for visits and consultations would be 27 percent greater."[14] In the final rule implementing the RBRVS, HCFA projected that family practice and general practice physicians would see payment *increases* of 30 percent and 29 percent, respectively, while general and thoracic surgery would see a *decrease* of 7 percent and 14 percent, respectively, in the first five years.[15]

In the CY 2021 PFS, CMS significantly increased the values for E/M codes but did not provide corresponding increases for E/M services included in the global codes, leading to an egregious devaluation of the global surgical packages. This departure from precedent creates specialty work differentials, contrary to the Medicare statute. The current policy implies that physician work for an office visit is less when performed in a global surgical period, which is incorrect.

After the first Five Year Review, HCFA initially declined to apply E/M increases to global codes. However, in the CY 1998 PFS final rule, the Agency stated, "Upon further examination of this issue, we are increasing the work RVUs for global surgical services to be consistent with the 1997 increases in the work RVUs for evaluation and management services."[16]

During the third Five Year Review, CMS (no longer called HCFA) agreed with the AMA RUC and stated in the CY 2007 proposed rule: "We are in agreement with these RUC recommended work RVUs for E/M services. We also agree with the recommendation that the full increase for

[13] 56 Fed. Reg. 59591 (November 25, 1991).
[14] 55 Fed. Reg. 36200 (September 4, 1990); *See also*, 56 Fed. Reg. 700 (January 8, 1991).
[15] Table 1, *Physician Fee Schedule Impact by Specialty,* 56 Fed. Reg. 59618 (November 25, 1991).
[16] Medicare: Physician Fee Schedule for Calendar Year 1998; Payment Policies and Relative Value Unit Adjustments and Clinical Psychologist Fee Schedule, 42 C.F.R. § 400 (1998).

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these codes should be incorporated into the surgical global periods for each Current Procedural Terminology (CPT) code with a global period of 010 and 090."[17]

The AMA RUC, along with most of the House of Medicine, has advocated that the incremental RVU changes to E/M services be incorporated into the global surgical packages because the work is equivalent, as evidenced by the revised E/M descriptors and guidelines. CMS has long provided this equitable treatment to maintain relativity within the PFS in the past. If particular surgical services need revaluation, CMS' Potentially Misvalued Services policy provides a mechanism for identifying those, and the AMA RUC has an ongoing process to revalue services. Since the enactment of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), this process has been used to review 222 10- and 90-day global codes, with CMS accepting the recommendations for the number and level of post-operative office visits as accurate for these codes, demonstrating CMS' acceptance of the AMA RUC's process.

Rationale for Maintaining 10- and 90- Day Global Surgical Packages

Number of Post-Operative Visits

At its October 2023 MedPAC meeting, MedPAC cites several sources[18,19, 20, 21] as "evidence of overvaluation of surgical services relative to other services."[22] These sources are flawed and should not serve as the basis for significant policy recommendations.

First, the RAND reports on CMS' Global Surgery Data Collection are based on a flawed data collection method, poorly publicized by CMS, and difficult for practices to operationalize. Findings from this approach should not justify across-the-board policy changes for global surgical packages.

The RAND Corporation also relied on a problematic survey conducted from September to December of 2018. This survey was fundamentally flawed in its attempt to collect accurate data on the time, staff, and resources involved in furnishing global surgical services. RAND acknowledged the low response rates: "15.5 percent overall (12.1 percent for cataract surgery, 16.0 percent for hip arthroplasty, and 18.5 percent for complex wound repair)."[23] This, coupled with methodological concerns make the survey results unreliable for policy recommendations.

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[17] Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology, 71 Fed. Reg. 37218 (June 29, 2006).
[18] Crespin et al 2022. Variation in estimated surgical procedure times across patient characteristics and surgeon specialty. *JAMA Surgery* 157, no. 5.
[19] MedPAC's Oct. 14, 2011 letter to Congress
[20] MedPAC's March 2006 report to the Congress
[21] Crespin et al. 2021. *Claims-based reporting of post-operative visits for procedures with 10- or 90-day global periods; Updated results using calendar year 2019 data* https://www.cms.gov/files/document/rand-cy-2019-claims-report-2021.pdf
[22] MedPAC October 2018 Meeting, *Considering current law updates to Medicare's payment rates for clinicians, slide 22,* https://www.medpac.gov/wp-content/uploads/2023/03/PFS-update-reform-MedPAC-Oct-2023-SEC.pdf.
[23] Courtney A. Gidengil, Andrew W. Mulcahy, Ateev Mehrotra, Susan L. Lovejoy, *Survey-Based Reporting of Post-Operative Visits for Select Procedures with 10- or 90-Day Global Periods Final Report*, xi.

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The ACS is committed to maintaining the accuracy of global surgical package values relative to the full RBRVS. The appropriate approach for revaluing services over time is the CMS Potentially Misvalued Code initiative and the AMA RUC process.

Intraservice Time

Criticisms of global surgical packages often lack a consistent basis. MedPAC combines concerns about time and packaged post-operative visits, but these are RVS-wide challenges. Discussing "time" solely in the context of surgical services without considering the entire RBRVS threatens system relativity. MedPAC also cited a study that attempts to use anesthesia time as a proxy for surgical intraservice time, which is not an accurate measure. The CMS Potentially Misvalued Code initiative and the AMA RUC process are the proper methods for maintaining accurate valuations over time.

Converting All Global Surgery to 0-day Global Codes

Although MedPAC is not explicitly recommending eliminating global codes, as recently as the April 2025 MedPAC meeting, the Commission has posited that a potential approach is to "[c]onvert 10- and 90-day global codes to 0-day global codes" in order to "[r]emove the portion of global RVUs attributed to post-operative visits."[24]

We are concerned that this described approach fails to critically consider the potential patient impact of such a change. The CMS proposal[25] to eliminate all 10- and 90-day global surgical packages prior to MACRA highlighted these concerns. Requiring patients to pay cost-sharing for each follow-up visit could dissuade them from returning for necessary care, adversely affecting surgical outcomes. MedPAC has provided no consideration of patient behavior changes that would result if patients were required to pay incremental cost-sharing for each post-operative visit that was performed nor how this could negatively impact patient surgical outcomes. We also stress the potential negative downstream impact on patient access if these misguided efforts are undertaken.

Further, MedPAC has failed to consider that the increased financial burden could be overwhelming, especially for sick patients. Because of the failure of CMS to update global surgical global packages with the recent increases to office/outpatient and inpatient E/Ms, global surgical packages now include what amounts to "discounted" E/M services provided by the surgical practice that performed the surgery. If Congress or CMS were to adopt the MedPAC approach of converting all global codes to 0-day, patients would then not only be subject to incremental cost-sharing for each post-op visit delivered after a surgery, but the patient would then be subject to the cost-sharing for the updated value of the E/Ms that were never translated to the global surgical packages. As an example, after the CY 2021 updates to E/Ms, a level 4 established office/outpatient visit increased in value by over 40 percent. Yet MedPAC makes no mention of the impact on patients of moving them from what are essentially "discounted" E/M

[24] MedPAC April 2025 Meeting, *Reforming physician fee schedule updates and improving the accuracy of relative payment updates*, Slide 12 (April 10, 2025).
[25] See, 79 Fed. Reg. 40341, *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015* (July 11, 2014).

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post-operative services to separately billed E/M codes. Further, any cost-sharing impact analyses would only be calculated for a beneficiary with a *typical* clinical course. MedPAC does not acknowledge that a more complex patient or a patient with more complications would require more post-operative visits than the "typical patient" and thus what is included in the global surgical package and would thus face higher costs due to additional visits *and* cost-sharing based on the recently increased values of E/M codes. Essentially, this approach is a proposal to charge sicker and more complex surgical patients more money for the severity of their condition.

Conclusion

Challenges will always exist with refining the valuation methodology and improving the accuracy of RVUs across the PFS. Those challenges must be addressed in ways that preserve the intent of the global surgery payment policy, ensuring the RVUs assigned to a surgical procedure continue to represent all facets of care after the decision for surgery has been made. Altering the global surgery payment policy to arbitrarily shift RVUs and Medicare funds to other services and specialties without regard to the actual resources and intensity required to provide surgical care would be grossly inappropriate and contrary to the goal of payment accuracy.

The ACS appreciates the opportunity to comment on these important issues and we look forward to continuing dialogue with the Commission on our policy priorities. Please contact Vinita Mujumdar, Chief of Regulatory Affairs, at vmujumdar@facs.org, with questions.

Sincerely,

Patricia L. Turner, MD, MBA, FACS
Executive Director and CEO

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