



# American College of Surgeons

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Donald M. Berwick, MD, MPP

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1582-PN

Room 445-G, Hubert H. Humphrey Building

200 Independence Avenue, SW

Washington, DC 20201

## Re: Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule

Dear Administrator Berwick:

On behalf of the more than 75,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the proposed rule: Medicare Program; Five-Year Review of Work Relative Value Units under the Physician Fee Schedule that was published in the *Federal Register* on May 26, 2011. 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. As requested in the proposed rule, the relevant "issue identifier" that precedes the section we are commenting on is used as a sub-heading to assist the Agency in reviewing these comments.

## Background - Five-Year Review of Work Process

In the Rule, CMS states: *"After compiling the list of potentially misvalued codes to be reviewed in the Fourth Five-Year Review of Work (Tables 1 through 4), we submitted the list to the AMA RUC. According to the AMA RUC's Five-Year Review timetable, upon receipt of the list of codes from CMS, the AMA RUC sent Level of Interest (LOI) forms to all specialty societies and the HCPAC so that the Five-Year Review codes could be reviewed initially by the appropriate specialty societies. To prepare for presentations of the codes to the AMA RUC, most specialty societies compiled data using a standard survey instrument whereby respondents compared the surveyed service with similar "reference" services for which there generally are well-established work values. Respondents were asked to estimate: the work RVU for the survey code; the time to perform the "pre-", "intra-", and "post-" service activities; and the technical skill, risk, and judgment involved with performing the service. Post-service activities were broken down into hospital and office visits and were assigned an appropriate evaluation and management (E/M) code by the respondents for the typical service."* [Emphasis added.] The College appreciates CMS' summary of the RUC survey process, but would like to make a clarification. CMS indicates post-service work reflects only E/M visits. However, in fact, post-service work also includes immediate post-service time through discharge from recovery. This is important, as we will discuss later, because CMS incorrectly proposes to move post-service E/M time into the immediate post-service time through discharge from recovery category.

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Further, we would like to take the opportunity to emphasize CMS' statement that the survey instrument is designed to compare total physician work of a survey code "*relative to a reference code.*" This concept of relativity, commonly referred to as magnitude estimation, was used by the Harvard research team for development of the first physician fee schedule and has been used by the AMA RUC for 20 years to review new, revised, and screened codes.

### **CMS Review of Five-Year Review Codes – CMS Analytical Approach**

With respect to CMS' review of physician work recommendations, ACS has identified a consequence that may arise as a result of implementation of this proposal. As you know, the Omnibus Budget Reconciliation Act (OBRA) of 1989 states "*the Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.*"<sup>1</sup> The policy changes proposed by CMS in this rule represent a clear change in payment policy that intentionally or unintentionally begins to create payment differentials based on provider specialty.

Specifically, physicians who did not perform the surgery but who round on post-surgical patients that are in the hospital are allowed to report full inpatient, outpatient, or observation E/M visit codes. However, for surgeons, CMS' new policy is to discount the E/M visit and only allow 0.22 work RVUs for a post-surgical visit even though the surgeon's evaluation and management work is equivalent. Additionally, CMS allows non-surgeons who discharge a medical patient to report a full discharge management code, even if the patient goes home after a one-night stay. For surgeons, however, CMS' new policy, if implemented, will reduce payment by 50 percent for the identical work performed by surgeons for their patients who are assigned outpatient facility status. Thus, the effect of the CMS proposed changes results in clear payment differentials based on provider specialty which we will discuss further in the following paragraphs.

#### *Valuing Post-operative E/M Visits*

In the CY 2011 PFS final rule with comment period (75 FR 73226 through 73227) CMS states "*we believe that the valuation of the codes that fall into the 23-hour stay category should not reflect work that is typically associated with an inpatient service.*" CMS further states "*However, we find it is plausible that while the patient receiving the 23-hour stay service remains a hospital outpatient, the patient would typically be cared for by the physician furnishing the procedure during that post-procedure period. While we do not believe that post-procedure hospital "visits" would be at the inpatient level since the typical case is an outpatient who would be ready to be discharged from the hospital in 23 hours or less, we agree that the intra-service time of the inpatient hospital visit may be included in the valuation for the 23-hour stay code.*"

In our previous comments to CMS regarding codes identified through the site-of-service screen, we have attempted to articulate the fact that facility designation of admission status (i.e., inpatient, outpatient,

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<sup>1</sup> 42 U.S. Sec. 1395w-4(c)(6)



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observation) is an artifact of recent changes in facility payment policy and recent use of criteria-based programs (e.g., InterQual) that assign admission status for purposes of facility reimbursement. The criteria for these programs are not based on physician work; they are based on facility resource utilization (e.g., nursing staff and ancillary services). Therefore, the CMS belief that a shift in reporting of facility status (inpatient vs. outpatient) would represent a decrease in physician work is faulty logic since facility admission status is not tied to physician work in the hospital that assigns facility status based upon standardized admission criteria.

The ACS has provided specific and detailed *clinical* information regarding physician work to CMS several times about this issue. Only 21 of over 150 codes identified by the RUC and CMS through the site-of-service screen include an argument and clinical rationale to support a distinct evaluation and management service on the day of the procedure. The Agency has not responded with any clinical evidence to refute these arguments and clinical rationales other than a "belief" regarding change in physician work based on change in facility status.

The ACS would like to reemphasize that a patient's facility status, which is related to facility resource utilization, does not relate to physician work. Evaluation and management codes are very descriptive of level of service with respect to history, exam, and medical decision making. CMS's decision to delete an E/M proxy and allow 10 minutes at 0.0224 intensity (work RVU = 0.22) to account for a surgeon's post-operative work belittles the work that surgeons perform to care for patients who must remain in the hospital because they are not stable enough to be discharged. A work RVU of 0.22 is just slightly more than the work RVU of 0.18 for 99211. Further the intensity of 0.0224 that CMS assigns in its "adjustment" is less than the intensity of 0.0270 for 99211. The Agency has ignored comments regarding the difference in the intensity of work for evaluation and management services as compared with immediate post-service intensity to perform such tasks as application of dressings and dictation of operative report. The ACS believes that this change represents a shift in payment policy that results in payment differential based on provider specialty.

#### *Valuing Post-operative Discharge Day Management*

In the rule, CMS proposes a new policy to assign 0.5 x 99238 for discharge management to any service with facility status outpatient, independent of the length of hospital stay. The RUC developed the idea of discounting discharge management to account for overlap in work during the post-operative period for same day surgery, whether performed in a hospital or ASC; more specifically, to account for the fact that the patient is not likely to undergo a full exam, including dressing removal and application, prior to discharge. In contrast to this, when a patient stays one or more nights in the hospital because they are not stable enough to be discharged, the discharge work on a day subsequent to the day of procedure would include a full exam of the patient, along with all other necessary discharge work. Although this logic has been presented to CMS several times, the Agency continues to misunderstand the logic of the RUC's development and implementation of 0.5 x 99238 for same-day surgery. CMS instead has chosen to extend this factor to any outpatient service, without regard to clinical rationale that justifies full discharge credit for patients that remain in the hospital for more than one day. CMS has not provided a clinical rationale or evidence that work



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is different. In fact, CMS's statement that a surgeon's work has changed because the facility status of the patient has changed due to recent changes in facility payment policy is unfounded. Furthermore, CMS's policy to reduce payment to surgeons for E/M work that is comparable to primary care is not justified. Over all the years of discussing this argument, CMS has never detailed how a surgeon's work has changed (i.e., to an intensity level below a nursing blood pressure check - 99211). The ACS continues to believe that the surgeon's evaluation and management work after discharge from recovery has not changed and is independent of facility status. As previously stated, this change represents a shift in payment policy that results in payment differential based on provider specialty.

Therefore, we reiterate that the shift in patient facility status for site-of-service codes under consideration in this Rule has nothing to do with healthier patients that require less physician work and everything to do with the recent OPSS changes related to facility reimbursement. Clinically and intellectually, there is no indication that patients undergoing surgery (designated "major surgery" with a 90-day global period) are suddenly healthier and less complex to manage. In fact, significant database examination would suggest the opposite.

#### *Reduction of Pre/Post Time and Work RVUs due to Same Day E/M Service*

CMS proposes to decrease time and work RVUs for codes that are typically billed with an E/M service on the same day. We disagree with CMS' belief that E/M related time and work RVUs are included in the RUC recommendations based on the following points: The RUC recommended pre-times are already reduced from the standard pre-time package. There is no evidence that the survey median immediate post-service time includes E/M post-service work. The instructions in the survey instrument specify that the respondent should not consider separately billable E/M work when completing the survey. There is no rationale to defend a specific percentage adjustment for all codes without regard to the procedure, site of service, or typical patient. The work RVU recommendations were not calculated using time components and therefore work RVUs should not systematically be subtracted.

#### **Code-Specific Discussions of Proposed Alternative Work RVUs**

##### **Drainage of Hematoma**

**CPT 10140** (Incision and drainage of hematoma, seroma or fluid collection) is not typically performed with an E/M service on the same day; it is typically performed in the office; and will typically require local anesthesia prior to incision. CMS accepts maintaining the work RVU, but has proposed decreasing the pre-service evaluation time from the standard pre-time package 5 (non-facility procedure with sedation/anesthesia care) from 17 minutes to 7 minutes. This is based on CMS's belief that the 1991 Harvard predicted pre-time of 7 minutes is more appropriate than the current survey data and pre-time package time.

We appreciate CMS's agreement with the current work RVU as supported by the survey data and comparison to reference codes. However, we disagree with CMS's proposed change to the pre-service time without justification. Prior to 1993, there were two codes to report incision and drainage of a hematoma; one code for



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simple I&D (10140) and one code for complicated I&D (10141). In 1993, code 10141 was deleted and code 10140 was revised to remove reference to simple or complicated. CMS calculated a new work RVU based on an average of the work RVUs for codes 10140 and 10141, weighted by the frequency with which each service was provided in 1991. The current time of 7 minutes that CMS believes is more appropriate was "predicted" using an algorithm that did not consider whether an E/M service was typically provided and did not consider the work related to administration of anesthesia. Furthermore, the 7 minutes was predicted only for old code 10140 (simple I&D) and not the revised blended code (simple or complex I&D).

The standard pre-time packages that the RUC utilizes and that have been supported by CMS took several years of RUC workgroup discussion to develop. The 17 minutes assigned for pre-time evaluation in package 5 compares well with E/M code 99202 (Office or other outpatient visit for the evaluation and management of a new patient) which has 15 minutes of intra-time (plus 7 min pre/post time) and does not include work related to anesthesia consideration or consent. We also note that the "value" for the E/M work allowed for this code is significantly less than the work RVU for the E/M service that is not typically reported [(pre-time package 5 time of min x 0.0224 = 0.38 RVUs) versus (99202 work RVUs = 0.93)]. Discounting the proxy time required for an E/M that is not reported is not appropriate. The ACS urges CMS to maintain the RUC recommended pre-time for code 10140.

### **Wound Repair**

Nineteen codes for intermediate wound repair (**CPT 12031-12057**) were surveyed as part of the Fourth Five-Year Review of Work. The RUC agreed with the compelling evidence submitted by the specialty societies that the previous methodology used to establish the work RVUs and physician time for the wound repair codes was flawed. After reviewing significant information regarding the Harvard review of these codes, the RUC determined that the original Harvard valuation led to compression within this family, which the RUC corrected by lowering the work RVUs for the smallest repair codes and increasing the work RVUs for the larger repair codes. CMS agreed with the RUC's determination that this family of codes experienced compression during the Harvard review: "*...our proposals for the revised work RVUs for the wound repair codes address concerns about compression in the original Harvard-valued work RVUs within the family.*"

CMS disagreed with the RUC's recommended values for nine of the 19 codes and proposed reducing the work RVUs for these nine codes to the survey 25<sup>th</sup> percentile as "consistent with the relativity adjustments recommended by the AMA RUC" for the other codes in the family. If all the codes in each family were homogenous in terms of providers and place of service, the rationale to use the same statistic, whether it is the 25<sup>th</sup> percentile or the same percentage adjustment, would be a reasonable. However, these codes are not provided by a homogenous group. The smaller size wound repair codes are more typically reported by dermatologists or emergency medicine physicians, while the large wound repair codes are more typically reported by surgeons. The RUC's determination to recommend the 25<sup>th</sup> percentile work RVU for the smaller repair codes and the median work RVU for the larger wound repair codes considered this difference; separately comparing the office-based family of smaller repair codes with the facility-based larger repair codes, followed by an overall ranking of work and intensity across all three families.



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Furthermore, in proposing the 25<sup>th</sup> percentile work RVU, CMS also disregarded the relationship to key reference services. For instance, the RUC recommendation for code 12035 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm) (RUC work RVU = 3.60) was appropriately slightly greater than key reference code 11406 (Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm) (work RVU = 3.52) taking into consideration complexity, intensity and site of service differential. CMS's proposed work RVU of 3.50 creates a rank order anomaly. Another example, the RUC recommendation for code 12036 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm) (RUC work RVU = 4.50) was appropriately slightly greater than key reference code 13121 (Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm) (work RVU = 4.42) taking into consideration greater intra- and total-time, complexity, intensity and site of service differential. Yet again, CMS's proposed work RVU of 4.23 creates a rank order anomaly. This same discussion regarding relativity and rank order applies to the other seven large wound repair codes where CMS proposes using the 25<sup>th</sup> percentile work RVU instead of the RUC recommendation. The ACS urges CMS to consider the logic presented in the discussion above regarding the relativity of these nine infrequently performed services and accept the RUC recommended work RVUs for codes 12035, 12036, 12037, 12045, 12046, 12047, 12055, 12056, and 12057.

CMS proposes changes to the recommended intra-time for some of the intermediate wound repair codes. We provided a compelling argument that the 75<sup>th</sup> percentile intra-time for codes 12036, 12055, 12056, and 12057 was more correct than the survey median intra-time based on an analysis of respondents with and without experience. We noted that for these codes, a significant number of providers who do not typically perform the procedure and per the survey did not have experience, still responded to the survey, resulting in an artificially reduced median intra-time. We acknowledge that by sending out a survey form with all codes in each family, we may have prompted responses from providers not familiar with all of the procedures. While an argument can be made that providers without experience in the same specialty may still be familiar with a procedure, the same argument cannot be made when the providers of a service are not homogenous. For example, all general surgeons may not perform a Whipple procedure every year, but all general surgeons will likely have performed one or more Whipple procedures in their career. On the contrary, the larger size wound repair codes are infrequently performed and are more often related to trauma resulting in many providers across all specialties never providing the service in their career. As we acknowledged above, the survey format may have prompted a response from providers to all codes in a family, even though they were not familiar with all of the codes, most importantly for infrequently performed repair of larger wound sizes. Therefore, it is statistically more valid to utilize the median intra-time data from providers with experience in performing the service. The ACS urges CMS to accept the RUC recommended intra-service times for codes 12036, 12055, 12056, and 12057.

CMS proposes changes to the recommended pre- and post-times for two of the intermediate wound repair codes (12046 and 12047) based on recent Medicare PFS claims data that show these services are typically performed on the same day as an E/M visit. First, we note that both codes are very infrequently performed (2010 Medicare utilization for code 12046 is 78 and for code 12047 is 48). Second, we note that the 2009



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Medicare same day billing occurrences provided to the RUC by CMS for the October 2010 meeting did not indicate these codes were typically billed with an E/M service. We note that codes with very low frequency often have erroneous data that may impact analysis. CMS's proposed reduction also disregards the fact that the recommended pre-evaluation time for these two codes is already significantly reduced from the standard pre-time package for procedures performed in a facility with sedation/anesthesia care. Specifically, pre-time package 1B evaluation time was already decreased from 19 minutes to 13 minutes, so further reduction is not warranted or justified. With respect to proposed reduction in post-time, we do not believe that there is evidence that E/M work was included in the survey immediate post-service time estimates. We urge CMS to accept the RUC recommended pre-service time and immediate post-service time for codes 12046 and 12047.

### **Partial Mastectomy**

**CPT 19302** (Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy), instead of the RUC recommendation to maintain the current work RVU of 13.99. CMS proposes an alternative work RVU. As justification, CMS states: *"After clinical review, we agree with the AMA RUC that CPT code 19302 is similar in work intensity and time to CPT code 38745 (Axillary lymphadenectomy; complete) (work RVU = 13.87), which overlaps significantly with CPT code 19302, and as such, we believe these two procedures should have the same work RVU."* However, what CMS does not acknowledge and account for is that the intra-time for 19303 is slightly greater than 38745 (100 minutes versus 90 minutes), supporting the current work RVU which is slightly greater (13.99 versus 13.87). Thus, we urge CMS to accept the AMA RUC recommended work RVU of 13.99 for code 19302.

### **Orthopaedic Surgery/Podiatry**

**CPT 28820** (Amputation, toe; metatarsophalangeal joint). CMS proposes an alternative work RVU and reduction in time based on review of 2009 Medicare PFS claims site of service data. However, we note that 2010 Medicare PFS data indicates inpatient claims of 53% which negates the site-of-service anomaly claim. We request CMS accept the RUC recommended work RVU, times, and visits as appropriate for 28820.

**CPT 28825** (Amputation, toe; interphalangeal joint). CMS proposes an alternative work RVU and reduction in time in accordance with the Agency policy discussed in section II.A. of the proposed notice. In the process of reviewing physician work for this code, we indicated that these patients typically have many co-morbidities including diabetes and/or will have bone infections requiring IV antibiotics. They require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. The hospital length of stay may be more dependent on the patient's diagnosis and not the procedure itself - although some patients may not undergo immediate primary closure. The wide variability of the length of stay is reflective of the difficult patient undergoing this procedure. We requested a change in the global period from 90-days to 0-day. CMS denied that request.

As we discussed in detail above, the surgeons post-operative E/M visits and discharge work is identical to the work that non-surgeons provide and is not tied to facility status assigned by hospitals for facility resource



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reimbursement. We request CMS accept the RUC recommended work RVU, times, and visits as appropriate for 28825.

Furthermore, we reiterate that both 28820 and 28825 should have a 000 global period so that post-service work can be reported as appropriate for the widely variable patient.

### **Vascular Surgery**

**CPT 36819** (Arteriovenous anastomosis, open; by upper arm basilic vein transposition). The RUC survey data show 97 percent of survey respondents stated they perform the procedure "in the hospital." This is consistent with Medicare data that show 97 percent of claims are in a hospital setting. However, CMS proposes an alternative work RVU and reduction in time in accordance with the Agency policy discussed in section II.A. of the proposed notice.

The surgeon's post-operative work on the day of the procedure has not changed and has not become easier because of a change in facility designation. For 36819, this work includes: reviewing interval nursing notes and labs in the patient's chart; assessing hemodynamic stability; assessing homeostasis at the surgical site and patency of the new dialysis access; assessing adequate blood flow to the hand beyond the new access; monitoring and managing post-operative pain; discussing ongoing care with the nursing staff; answering patient/family questions; and charting interval notes and orders. In cases where the patient is stable and can safely be discharged on a day subsequent to the day of the procedure, we also contend there is no reduction in discharge management work and this work is equivalent to any physician providing discharge management services. These renal failure patients have significant co-morbidities and significant potential problems.

The surgeon's discharge work, independent of facility status, continues to include: reviewing interval chart notes; evaluating vital signs and intake/output; a full neurovascular evaluation of the extremity; wound evaluation for potential hemorrhage; fistula evaluation to ensure patency; glycemic assessment; physical exam to ensure the IV fluid administered by anesthesia has not pushed patient into acute heart failure; provision of wound care instructions, provision of warnings for vascular steal syndrome and/or vascular compromise of the hand, ensuring arrangements are made to reestablish outpatient hemodialysis; and finalization of many other details including orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms. We believe that it is egregious to say that this work is 50% of the work for the typical patient described by primary care.

As we discussed in detail above, the surgeons post-operative E/M visits and discharge work is identical to the work that non-surgeons provide and is not tied to facility status assigned by hospitals for facility resource reimbursement. We request CMS accept the RUC recommended work RVU, times, and visits for 36819.

**CPT 36825** (Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft). The RUC survey data show 100 percent of survey respondents stated they



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perform the procedure "in the hospital." This is consistent with Medicare data that show 97 percent of claims are in a hospital setting. However, CMS proposes an alternative work RVU and reduction in time in accordance with the Agency policy discussed in section II.A. of the proposed notice.

The surgeon's post-operative work on the day of the procedure has not changed and has not become easier because of a change in facility designation. For 36825, this work includes: reviewing interval nursing notes and labs in the patient's chart; assessing hemodynamic stability; assessing homeostasis at the surgical site and patency of the new dialysis access; assessing adequate blood flow to the hand beyond the new access; monitoring and managing post-operative pain; discussing ongoing care with the nursing staff; answering patient/family questions; and charting interval notes and orders. If the patient is stable and can safely be discharged on a day subsequent to the day of the procedure, we contend there is no reduction in discharge management work. These renal failure patients have significant co-morbidities and significant potential problems.

The surgeon's discharge work, independent of facility status, continues to include: reviewing interval chart notes; evaluating vital signs and intake/output; a full neurovascular evaluation of the extremity; wound evaluation for potential hemorrhage; fistula evaluation to ensure patency; glycemic assessment; physical exam to ensure the IV fluid administered by anesthesia has not pushed patient into acute heart failure; provision of wound care instructions, provision of warnings for vascular steal syndrome and/or vascular compromise of the hand, ensuring arrangements are made to reestablish outpatient hemodialysis; and finalization of many other details including orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms. We believe that it is egregious to say that this work is 50% of the work for the typical patient described by primary care.

As we discussed in detail above, the surgeons post-operative E/M visits and discharge work is identical to the work that non-surgeons provide and is not tied to facility status assigned by hospitals for facility resource reimbursement. We request CMS accept the RUC recommended work RVU, times, and visits for 36825.

### **Excise Parotid Gland/Lesion**

**CPT 42415** (Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve). The RUC survey data show 97 percent of survey respondents stated they perform the procedure "in the hospital." This is consistent with Medicare data that show 92 percent of claims are in a hospital setting. However, CMS proposes an alternative work RVU and reduction in time in accordance with the Agency policy discussed in section II.A. of the proposed notice.

The surgeon's post-operative work on the day of the procedure has not changed and has not become easier because of a change in facility designation. For 42415, this work includes: reviewing interval nursing notes and labs in the patient's chart; assessing hemodynamic stability; examining the patient; checking wounds and drain; checking flaps for viability; assessing airway patency; assessing facial nerve function; monitoring and



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managing post-operative pain; discussing ongoing care with the nursing staff; answering patient/family questions; and charting interval notes and orders.

The surgeon's discharge work, independent of facility status, continues to include: reviewing interval chart notes; evaluating vital signs and intake/output; examining the patient; checking wounds and drain; checking flaps for viability; assessing airway patency; assessing facial nerve function; and finalization of many other details including orders for follow-up, post-discharge labs, diet, medications and supplies. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms. We believe that it is egregious to say that this work is 50% of the work for the typical patient described by primary care.

As we discussed in detail above, the surgeons post-operative E/M visits and discharge work is identical to the work that non-surgeons provide and is not tied to facility status assigned by hospitals for facility resource reimbursement. We request CMS accept the RUC recommended work RVU, times, and visits for 42415.

**CPT 42420** (Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve). The RUC survey data show 100 percent of survey respondents stated they perform the procedure "in the hospital." This is consistent with Medicare data that show 94 percent of claims are in a hospital setting. However, CMS proposes an alternative work RVU and reduction in time in accordance with the Agency policy discussed in section II.A. of the proposed notice.

For 42420, the RUC presented the argument that the typical patient will remain in the facility at least two nights after the day of the procedure. Specifically, patients are maintained on IV fluids until oral intake is possible, which is clinically unlikely well into the day after the procedure and possibly several days later. Close monitoring of functional issues related to speech, mastication, and eye closure is important. CMS did not disagree that E/M visits over several days were required post-operatively while the patient is in the hospital, but reduced the value and time in accordance with their new policy.

The surgeon's post-operative work has not changed and has not become easier because of a change in facility designation. For 42420, this work includes: reviewing interval nursing notes and labs in the patient's chart; assessing hemodynamic stability; examining the patient; checking wounds and drain; checking flaps for viability; assessing airway patency; assessing facial nerve function; monitoring and managing post-operative pain and functional issues; discussing ongoing care with the nursing staff; answering patient/family questions; and charting interval notes and orders.

The surgeon's discharge work, independent of facility status, continues to include: reviewing interval chart notes; evaluating vital signs and intake/output; examining the patient; checking wounds and drain; checking flaps for viability; assessing airway patency; assessing facial nerve function; and finalization of many other details including orders for follow-up, post-discharge labs, diet, medications and supplies. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge



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instructions, and insurance forms. We believe that it is egregious to say that this work is 50% of the work for the typical patient described by primary care.

As we discussed in detail above, the surgeons post-operative E/M visits and discharge work is identical to the work that non-surgeons provide and is not tied to facility status assigned by hospitals for facility resource reimbursement. We request CMS accept the RUC recommended work RVU, times, and visits for 42420.

### **Laparoscopic Cholecystectomy**

**CPT 47563** (Laparoscopy, surgical; cholecystectomy with cholangiography). The RUC survey data show 95 percent of survey respondents stated they perform the procedure "in the hospital." This is consistent with Medicare data that show 97 percent of claims are in a hospital setting. However, CMS proposes an alternative work RVU and reduction in time in accordance with the Agency policy discussed in section II.A. of the proposed notice.

We note that more than half of the survey respondents indicated a change in work in the past five years; specifically, a more complex patient population. In the past five years, an increased number of patients undergoing this procedure are more obese with more co-morbidities such as hypertension, diabetes, and heart disease. In addition, advances in technology have led to a change in medical management (i.e., medications, ERCP) resulting in a more complex patient presenting for surgery and requiring cholangiography.

The surgeon's post-operative work has not changed and has not become easier because of a change in facility designation. For 47563, this work includes: review of interval chart notes; discussion of ongoing care with floor nurses; evaluation of vital signs and intake/output; auscultation of heart, lungs, and abdomen for bowel sounds; monitoring of fluid and electrolyte status and renal function; assessing the wound; managing prophylaxis for DVT; assessing need for beta-blockers; assessing need for continued antibiotics; assessing pain scores and adequacy of analgesia; reviewing nursing/other staff patient chart notes; writing orders for labs and films (as indicated), medications, diet, and patient activity; charting patient progress notes; answering patient and family questions; answering nursing/other staff questions; advancing diet, as appropriate; and managing drain including removal when appropriate.

The surgeon's discharge work, independent of facility status, continues to include: reviewing interval chart notes; evaluating vital signs and intake/output; examining the patient; discussion of the hospital stay, and instructions for continuing care to all relevant caregivers. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms. We believe that it is egregious to say that this work is 50% of the work for the typical patient described by primary care.

As we discussed in detail above, the surgeons post-operative E/M visits and discharge work is identical to the work that non-surgeons provide and is not tied to facility status assigned by hospitals for facility resource reimbursement. We request CMS accept the RUC recommended work RVU, times, and visits for 47563.



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**CPT 47564** (Laparoscopy, surgical; cholecystectomy with exploration of common duct). CMS accepts the RUC survey data, but disagrees with the RUC recommendation of the 25th percentile work RVU. In the rule, CMS proposes a work RVU of 18.00 which is the survey low response. CMS states that their alternative work RVU "is more appropriate given the significant reduction in recommended physician times in comparison to the current times."

Although CMS does not discuss compelling evidence in the Rule, we assume CMS agrees that there is compelling evidence that 47564 is misvalued. First we note that the initial methodology in 1994 to crosswalk the value and times for 47564 from 47610 was flawed. Both the RUC and CMS have since rescinded their policy to match work RVUs for open and laparoscopic procedures. Second, we note that 64 percent of the survey respondents indicated a change in work in the past five years, specifically, more complex. We believe that if the question of change in work reflected a change since 1994, when the code was new, we suspect the response would have been 100%. This belief reflects a changed patient population (i.e., more obese with more co-morbidities) and advances in technology that have led to a change in medical management (i.e., medications, ERCP) resulting in a more complex patient presenting for surgery requiring exploration of the common duct. As indicated in the typical patient vignette, patients undergoing 47564 in current practice have failed ERCP, have known gallstones, and are sick.

As a result of 47564 becoming a new code in 1994, being offered and rejected for review in 2000, and having a low volume, the College did not recommend review in 2005. The current review of this code, at the request of CMS represents the first time that 47564 is surveyed. The current times in the database are based on CMS crosswalking in 1994 and not based on any survey (Harvard or RUC). Therefore, CMS's rationale to reduce the RUC recommendation because of a comparison of current survey time and database time is not valid. The ACS does not agree with CMS's choice of using the low survey statistic as valid without a corresponding reference to support the recommendation and we do not agree with CMS's alternative work RVU of 18.00 as a relative value. We urge CMS to accept the AMA RUC recommended a work RVU of 20.00 for CPT code 47564.

### **Hernia Repair**

**CPT 49507** (Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated), **CPT 49521** (Repair recurrent inguinal hernia, any age; incarcerated or strangulated), and **CPT 49587** (Repair umbilical hernia, age 5 years or older; incarcerated or strangulated). For these three hernia repair codes, the RUC survey data show 98-100 percent of survey respondents stated they perform the procedure "in the hospital." This is similar to Medicare data that show 92-96 percent of claims are in a hospital. However, CMS proposes alternative work RVUs and reduction in time in accordance with the Agency policy discussed in section II.A. of the proposed notice.

The work RVUs for 49507, 49521, and 49587 were never calculated using a building block methodology. Specifically, The RUC process in 1993 utilized consistent ratios for valuing each type of hernia (reducible, incarcerated/strangulated, initial, and recurrent), with a goal of maintaining budget neutrality across all hernia



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codes. In 2000, during the second 5-year review, the hernia codes were surveyed as mini-surveys and the work RVUs adjusted using the percentage change made to 49505 (Repair initial inguinal hernia, age 5 years or older; reducible), which underwent a full RUC survey. Many of the more difficult procedures had evidence to support higher values, but the details of the codes with mini-surveys were not reviewed on a code-by-code basis. Therefore, to remove time and work RVUs in a mathematical fashion is contrary to the methodology used to assign the work RVU.

The surgeon's post-operative work has not changed and has not become easier because of a change in facility designation. For codes 49507, 49521, and 49587, this work includes: review of interval chart notes; discussion of ongoing care with floor nurses; evaluation of vital signs and intake/output; auscultation of heart, lungs, and abdomen for bowel sounds; monitoring of fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention; examining the patient and checking wounds and drain; assessing the need for continued prophylaxis for DVT and need for beta-blockers; monitoring and managing post-operative pain; discussing ongoing care and diet with the nursing staff; answering patient/family questions; and charting interval notes and orders.

The surgeon's discharge work, independent of facility status, continues to include: review of interval chart notes; evaluation of vital signs and intake/output; auscultation of heart, lungs, and abdomen for bowel sounds; assessing fluid and electrolyte status and renal function; assessing for problems such as ileus, intestinal ischemia, and urinary retention; examining the patient and checking wounds and drain; and assessing the need for continued prophylaxis for DVT and need for beta-blockers. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. The surgeon will write orders for follow-up, post-discharge labs, x-rays, home care, physical therapy, and prescriptions. Home restrictions and activity levels (i.e., diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms. We believe that it is egregious to say that this work is 50% of the work for the typical patient described by primary care.

As we discussed in detail above, the surgeons post-operative E/M visits and discharge work is identical to the work that non-surgeons provide and is not tied to facility status assigned by hospitals for facility resource reimbursement. We request CMS accept the RUC recommended work RVU, times, and visits for 49507, 49521, and 49587.

### **Laparoscopic Hernia Repair**

**CPT 49652** (Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible), **CPT 49653** (Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated), **CPT 49654** (Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible), and **CPT 49655** (Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated). For these four laparoscopic hernia repair codes, the RUC survey data show 100



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percent of survey respondents stated they perform the procedure "in the hospital." This is similar to Medicare data that show 97-99 percent of claims are in a hospital. However, CMS proposes an alternative work RVU and reduction in time in accordance with the Agency policy discussed in section II.A. of the proposed notice.

We note that the work RVUs for these four laparoscopic hernia repair codes were not calculated using building blocks. When the RUC reviewed these codes, the specialty recommendations were not accepted, and instead the RUC recommended the 25th percentile work RVU, which represented a significant decrease from the survey data and specialty recommendation. In addition, the RUC recommendations were well below the sum of the comparable open procedures plus implantation of mesh.

The surgeon's post-operative work has not changed and has not become easier because of a change in facility designation. For codes 49652, 49653, 49654, and 49655, this work includes: review of interval chart notes; discussion of ongoing care with floor nurses; evaluation of vital signs and intake/output; auscultation of heart, lungs, and abdomen for bowel sounds; monitoring of fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention; examining the patient and checking wounds and drain; assessing the need for continued prophylaxis for DVT and need for beta-blockers; monitoring and managing post-operative pain; discussing ongoing care and diet with the nursing staff; answering patient/family questions; and charting interval notes and orders.

The surgeon's discharge work, independent of facility status, continues to include: review of interval chart notes; evaluation of vital signs and intake/output; auscultation of heart, lungs, and abdomen for bowel sounds; assessing fluid and electrolyte status and renal function; assessing for problems such as ileus, intestinal ischemia, and urinary retention; examining the patient and checking wounds and drain; and assessing the need for continued prophylaxis for DVT and need for beta-blockers. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. The surgeon will write orders for follow-up, post-discharge labs, x-rays, home care, physical therapy, and prescriptions. Home restrictions and activity levels (i.e., diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms. We believe that it is egregious to say that this work is 50% of the work for the typical patient described by primary care.

As we discussed in detail above, the surgeons post-operative E/M visits and discharge work is identical to the work that non-surgeons provide and is not tied to facility status assigned by hospitals for facility resource reimbursement. We request CMS accept the RUC recommended work RVU, times, and visits for 49652, 49653, 49654, and 49655.

### **Removal of Thyroid/Parathyroid**

**CPT 60220** (Total thyroid lobectomy, unilateral; with or without isthmusectomy), **CPT 60240** (Thyroidectomy, total or complete), and **CPT 60500** (Parathyroidectomy or exploration of parathyroid(s)). For these three thyroid/parathyroid codes, the RUC survey data show 97 percent of survey respondents stated



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they perform the procedure "in the hospital." This is similar to Medicare data that show 98-99 percent of claims are in a hospital. However, CMS proposes an alternative work RVU and reduction in time in accordance with the Agency policy discussed in section II.A. of the proposed notice.

We note that the work RVUs for these three codes were not calculated using building blocks. When the RUC reviewed these codes, the survey data supported work RVUs above the current value, but the RUC recommended maintaining the current work RVUs, which were well below the survey 25th percentile.

The surgeon's post-operative work has not changed and has not become easier because of a change in facility designation. For codes 60220, 60240, and 60500, this work includes: review of interval chart notes; discussion of ongoing care with floor nurses; evaluation of vital signs and intake/output; auscultation of heart and lungs; monitoring of fluid and electrolyte status and renal function; monitoring serum calcium levels (60240 and 60500); monitoring airway patency and cervical hematoma; examining the patient and checking wounds and drain; assessing the need for continued prophylaxis for DVT and need for beta-blockers; monitoring and managing post-operative pain; discussing ongoing care and diet with the nursing staff; answering patient/family questions; and charting interval notes and orders.

The surgeon's discharge work, independent of facility status, continues to include: review of interval chart notes; evaluation of vital signs and intake/output; auscultation of heart and lungs; assessing fluid and electrolyte status and renal function; monitoring serum calcium levels, assessing for problems such as airway patency, hoarseness, stridor, and cervical hematoma; examining the patient and checking wounds and drain; and assessing the need for continued prophylaxis for DVT and need for beta-blockers. The patient will not be discharged until stable, taking adequate nutrition, and there is adequate pain control with oral analgesics. The surgeon will write orders for follow-up, post-discharge labs, x-rays, home care, physical therapy, and prescriptions. Home restrictions and activity levels (ie, diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms. We believe that it is egregious to say that this work is 50% of the work for the typical patient described by primary care.

As we discussed in detail above, the surgeons post-operative E/M visits and discharge work is identical to the work that non-surgeons provide and is not tied to facility status assigned by hospitals for facility resource reimbursement. We request CMS accept the RUC recommended work RVU, times, and visits for 60220, 60240, and 60500.

Attached is a table that includes the codes we have commented on in this letter, highlighting the proposed CMS changes with which we disagree. In all instances, we urge CMS to accept the RUC recommendations.

The ACS remains committed to improving the quality of patient care, and continues to be actively engaged in the review of potentially misvalued codes and we look forward to working with the RUC and CMS in the future on such reviews. As always, we appreciate your consideration of these comments. We will continue to carefully monitor future correspondence on these and other relevant health care issues.



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The American College of Surgeons would be happy to answer any additional questions regarding these comments. Please feel free to direct any questions to Bob Jasak, Assistant Director for Regulatory and Quality Affairs at [bjasak@facs.org](mailto:bjasak@facs.org) or phone: 202-672-1508.

Sincerely,

A handwritten signature in black ink that reads "David B. Hoyt".

David B. Hoyt, MD, FACS  
Executive Director



