

**Statement  
of  
American College of Surgeons**

**to  
House Energy and Commerce Committee  
Subcommittee on Health**

**by  
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**RE: Medicare Physician Payment: How to Build a  
Payment System that Provides Quality, Efficient Care  
For Medicare Beneficiaries**

**July 27, 2006**

Chairman Deal, Ranking Member Brown, and distinguished subcommittee members, thank you for the opportunity to testify today on behalf of the 71,000 Fellows of the American College of Surgeons (ACS). My name is Frank Opelka. I practice colorectal surgery in New Orleans, and serve as Associate Dean for Healthcare Quality and Safety at Louisiana State University. I also serve as the Chair of the Surgical Quality Alliance.

We are grateful to you for holding this hearing on the Medicare physician payment system and, specifically, how to build a payment system that provides high-quality and efficient care for Medicare beneficiaries. ACS has been a leader in the effort to improve the quality of our nation's surgical care for many years. A detailed description of key ACS efforts is included at the end of this testimony in Attachment A.

ACS supports the concept of value-based purchasing and shares the view that it holds real potential to bring value to patients through improved quality and informed choices. Our concerns arise in reference to the development and implementation of some of these specific value-based purchasing programs.

This morning, I would like to discuss some of the current quality improvement efforts and some of the unique issues confronting performance measurement in surgery. In addition, I would like to discuss the relationship between value-based purchasing and the current physician payment environment. Quality improvement programs will only reach their full potential if an appropriate payment system is created in which high-quality care and quality improvement are encouraged. This is impossible under the constructs of Medicare's current physician payment system, which we all understand is unsustainable. ACS believes that we have a solution that would significantly improve the payment system and allow quality improvement efforts to thrive.

## Unique Issues Confronting Performance Measurement in Surgery

Surgical care is provided in a variety of settings including hospitals, offices, and ambulatory surgery centers. While our ability to provide care in diverse settings can bring value to the patient and the healthcare system, it also creates complexities. For example, responsible reporting of clinical information for quality monitoring and improvement can be especially difficult when a patient's course of treatment occurs across multiple settings.

Regardless of the setting, surgical care is provided as part of a system or team. The surgeon is one member of a team that also includes nurses, anesthesiologists, technicians, and other staff. Many gaps in the quality of surgical care exist in areas of overlap between participants in the system. For instance, the surgeon, anesthesiologist, nurse, and pharmacist all contribute to the patient receiving appropriate and timely prophylactic antibiotics. This team-oriented approach to surgical care can complicate the development of measures addressing accountability at a physician level rather than system level. Divergent views on whether measures in a pay-for-performance system should focus on surgeon or system performance have become a serious obstacle to measure development and implementation. Indeed, given the unique team-oriented environment in which surgeons practice, few performance measures existed that focused on the individual surgeon. ACS has been working with the surgical specialty societies over the past year to identify areas that can be attributed directly to the surgeon, such as ordering of various therapies, for use in value-based purchasing initiatives.

Additionally, each surgical setting presents its own unique challenges in measuring performance. For many procedures performed in a hospital setting, risk-adjusted patient outcomes are the preferred method of measuring performance. Risk adjustment is a necessary component of surgical outcomes data and should include adjustment for age, weight, and co-morbid conditions, such as diabetes, that could affect the patient's risk. Currently, accurate risk-adjustment models can only be used in conjunction with clinical data because administrative data do not capture all of the necessary data points required for accuracy. In addition, claims are submitted well before the 30-day outcome of an operation is known, making them a poor vehicle to report outcomes data. Finally, current risk-adjustment tools focus on a system of care as with ACS National Surgical Quality Improvement Program (NSQIP) data, instead of on an individual physician or surgeon.

On the other hand, most procedures performed in an office or ambulatory surgery center have extremely good outcomes with few complications. This presents a challenge for the surgical specialties in the development of useful and valid measures that close a gap in care and can be used in value-based purchasing programs. Traditional outcome and process measures are not appropriate in these settings if a gap in care cannot be identified. This challenge of measurement must be addressed as we move toward a pay-for-performance system.

Finally, surgery has become a highly specialized profession in which a surgeon may only perform a small fraction of the thousands of CPT codes that address surgical procedures. Developing measures that capture a significant portion of each specialty's procedures or that are applicable to multiple specialties has been a challenging and time-consuming task. The Surgical Quality Alliance (SQA) took on this daunting task and developed four global, process measures for surgical care. These measures were twice

mitted along with proposed revisions to the Centers for Medicare & Medicaid Services (CMS) for inclusion in the Physician Voluntary Reporting Program (PVRP).

- Preoperative Smoking Cessation – Smoking prior to surgery can lead to increased incidence of wound complications, diminished vascularity, and poor wound healing. Preoperative smoking cessation results in fewer complications and faster healing leading to an easier recovery for the patient and reduced strain on the healthcare system.
- Surgical Timeout – Participation in a preoperative surgical timeout in which the patient, procedure(s), and surgical site(s) are identified and agreed upon by the surgical team leads to fewer adverse events including wrong-site, wrong-side, wrong-procedure, and wrong-person operations.
- Patient Copy of Preoperative Instructions – Adverse events occur when patients are not fully informed prior to surgery. Patients should be given a copy of preoperative instructions that can be taken home, easily read and referred to, and shared with appropriate family, friends and/or caregivers prior to surgery.
- Patient Copy of Postoperative Instructions – Keeping patients informed and engaged in their own care leads to fewer complications and readmissions following surgery. Postoperative instructions should be easy to read and reference and should include information on activity level, diet, discharge medications, proper incision care (if applicable), symptoms of surgical site infection, what to do if symptoms worsen, and follow-up appointments.

### **Physician Voluntary Reporting Program (PVRP)**

ACS welcomed the introduction of the PVRP as the “pilot test” physician organizations had requested prior to implementation of a payment-related quality reporting system. A voluntary program is a vital step to examine potential administrative and workflow challenges involved in collecting data from individual physicians on performance-related issues. Nonetheless, the following points have been identified by ACS and other surgical societies as obstacles in the PVRP as it is currently constructed that need to be addressed:

- The surgical measures reflect broader hospital accountability and do not focus directly on the surgeon’s responsibility. This focus on the facility/system in a physician-oriented program severely limits the usefulness of the data collected for quality improvement purposes.
- Many numerators and denominators are incorrect, and CMS has been unresponsive to surgery’s efforts to recommend changes. The rationale behind CPT codes selected for the program and those excluded is not apparent, and codes appear to have been selected randomly. In addition, some of the codes challenge the credibility of the program, which further presents obstacles to encouraging participation by surgeons.
- As the PVRP measures are currently defined, it is difficult for surgeons to participate. The CPT codes included in the surgical measures are limited and do not allow for participation by many surgical specialties. As a result, we are not really “testing” how patient care information can be retrieved and reported across inpatient and outpatient settings.

In a live surgical patient, a deep vein thrombosis (DVT) (or blood clot) is a severe and potentially life-threatening complication; fortunately, a number of preventive measures are effective in reducing the incidence of DVT. However, it is unnecessary to guard against DVT in procedures involving a cadaver donor. Yet, CMS' list of procedures for which DVT prevention is to be used includes four procedures for harvesting an organ(s) from a cadaver--lung (CPT code 32850), heart-lung (code 33930), liver (code 47133) and kidney (code 50300). To further show the arbitrary nature of the list, CMS properly excludes harvesting the heart (code 33940).

A prophylactic antibiotic should be given when there is significant risk of acquiring an infection during a surgical procedure. While many factors contribute to a patient's risk for a surgical site infection, one determinant is the length of the procedure. Whipple-type procedures are open procedures in which part of the pancreas is removed and extensive surgery is performed on nearby organs. We can obtain the length of the time from incision to closing of the wound (known as "skin-to-skin" time) from a database maintained by the American Medical Association/Specialty Society Relative Value Update Committee (RUC) and available to CMS. The skin-to-skin times for the four Whipple-type procedures are 290 to 360 minutes. Yet, none of the four Whipple-type procedures is on the list for antibiotic administration.

Throughout the codebook, there are codes for procedures that are not listed in CPT. (For example, code 43999 is "Unlisted procedure, stomach".) We expected that CMS would be consistent in their treatment of these codes, but they are not. The PVRP includes unlisted procedures for the intestine, rectum and cardiac surgery, but not for the esophagus, stomach, liver or other anatomical areas.

End stage renal disease (ESRD) patients on hemodialysis need vascular access to connect their bloodstream to the dialysis machine. There are many types of vascular access, but fistulas have the lowest failure and complication rates. Fistula access involves connecting a patient's own vein and artery, instead of connecting a prosthetic tube to the artery or placing a plastic catheter into the vein, both of which are associated with higher morbidity and mortality rates. It is important to place a native access in patients before they advance to ESRD status because a fistula cannot be used immediately as it needs time to mature. However, the PVRP measure for receipt of autogenous arteriovenous fistula applies only to ESRD patients. The SQA, including the Society for Vascular Surgery, proposed the addition of advanced chronic kidney disease patients to promote fistula use prior to ESRD and to obtain a more accurate representation of current fistula use.

Our concerns with the PVRP are outlined in two letters from the SQA to CMS administrator Mark McClellan, MD, PhD. The letters also include the four global, process measures for surgery listed above. The March 1 and June 1 letters are included as Attachment B to this testimony.

## **Progress in the development of surgical measures**

In addition to the measure revisions and global process measures submitted to CMS the SQA, the surgical community has been working with various quality organizations to develop and implement surgical performance measures. ACS continues to work with the AHA's Physician Consortium for Performance Improvement (PCPI) serving as the lead organization for two Perioperative Care Workgroups. The first perioperative workgroup focused on the assessment of cardiac risk, while the second is focused on the prevention of surgical site infections and DVT. The current measure set includes appropriate timing, selection, and discontinuation of prophylactic antibiotics as well as appropriate DVT prophylaxis for selected surgical procedures. The measure set is open for public comment through August 4. Surgical specialty societies are also working with the PCPI to develop measure sets for eye care, osteoporosis, stroke, and skin cancer.

The Society for Thoracic Surgeons participated in the National Quality Forum's (NQF) project to develop a set of consensus standards for cardiac surgery. A slightly refined version of the NQF-endorsed cardiac surgery measure set, specific to coronary artery bypass graft, was also approved by the AQA as the starter set for measuring cardiac surgery. In addition, ACS continues to participate in the NQF's cancer care project and has submitted measures relating to diagnosis and treatment of colon and breast cancer, some of which we told are being considered for modification and inclusion in the PVRP.

The SQA recently embarked on a project to address surgical performance measurement in the ambulatory and office settings. As stated earlier, these environments provide unique challenges in a quality improvement initiative because patient outcomes are extremely good. SQA project participants met earlier this month and developed a starter set of measures that include structure, process, adverse-event reporting, and patient satisfaction measures applicable to ambulatory and office-based care.

## **Reporting Quality and Performance Data**

Healthcare is comprised of many stakeholders, including the purchasers of health insurance, the insurers who sell and contract for care, the providers including physicians, hospitals, and nursing homes, and most importantly, the patients. Each stakeholder has a unique perspective, investment, and interest in quality improvement and reporting. Patients use reports to make informed decisions about healthcare providers; payers and purchasers use reports to contract with providers who produce high-quality and efficient care; and, providers use reports to influence the strategic direction of internal quality improvement efforts.

Given the important and distinctive interests of each stakeholder, reports and performance measures must be developed and designed with a specific goal in mind. Different data elements are important to different healthcare stakeholders. For instance, complex clinical data points may not be as valuable to consumers as they are to providers for internal quality improvement efforts.

Regardless of the audience, however, accurate data and the appropriate context of that data are integral to improving quality. It is easy to make incorrect assumptions about the quality of a healthcare provider based on incomplete data. Current performance measure

Measures are comprised primarily of process measures that examine a point of care, including assessment of elderly patients for falls for primary care physicians and ordering of antibiotics for surgeons. Process measures are important to quality improvement efforts because they are an actionable item for the physician or system being measured. In addition, process measures have been favored because they are easily reported using the claims processing system. However, process measures alone do not define the quality of a surgeon, because compliance with process measures does not guarantee high-quality outcomes. For example, a surgeon who complies with antibiotic process measures but has high morbidity rates due to poor technique is not a high-quality surgeon.

To accurately represent the overall quality of a surgeon, a report must contain many variables, including risk-adjusted outcome (observed outcome/expected outcome), process, structure, patient satisfaction, and quality-of-life measures. ACS continues to collaborate with multiple stakeholders in an effort to develop an appropriate and comprehensive measure that incorporates many quality areas.

Another important component in value-based purchasing is the cost of the services provided. As our nation's healthcare expenditures continue to rise, methods to reduce cost have been widely examined. Cost of care measures are controversial, complex, and are easy to misuse. In linking cost of care measures to quality to develop "efficiency" measures, there is the potential to greatly amplify the errors that exist in the cost component of the measure.

### **The Current Payment Crisis**

While value-based purchasing can improve the quality of care patients receive and allow healthcare stakeholders to make informed decisions about healthcare, it cannot fix the broken Medicare physician payment system. The benefits of a value-based purchasing system will not be fully realized until a stable, fair physician payment system is implemented. The College urges Congress to prevent the 4.7 percent payment cut that will go into effect on January 1, 2007, and explore long-term solutions to this ever-growing problem.

### **The Sustainable Growth Rate Formula is Broken**

For the sixth year in a row, Medicare payments to physicians are scheduled to be cut under the sustainable growth rate (SGR) formula. In 2002, Medicare physician payment was cut by 5.4 percent, and in 2003, 2004, 2005, and 2006 Congress took action to override the SGR and prevent the predicted payment cuts. The Medicare Payment Advisory Commission (MedPAC), CMS Administrator McClellan, and numerous other authorities and policymakers have acknowledged the SGR's problems and limitations and have called on Congress to fix the broken formula. Under the SGR formula, Medicare physician payment will be cut across-the-board by more than 37 percent by 2015, while at the same time the cost of providing care will increase by 20 percent. Simultaneously, other providers, including hospitals and skilled nursing facilities, are enjoying yearly increases in payment rates.

### **4.7 Percent January 1, 2007 Cut Must be Prevented**

While ACS greatly appreciates Congress' actions over the past six years to prevent the payment cuts, it is more important than ever that Congress take action to prevent the 4.7

percent cut scheduled for January 1, 2007. The conversion factor increases and freezes over the past several years have not kept pace with the rising cost of delivering care to Medicare beneficiaries. Since 2001, the Medicare Economic Index (MEI) has risen 16 percent, but the conversion factor has decreased and is less than it was in 2001. These differences have been offset by physician practices that are not likely to be able to absorb additional disparities. In its March 2006 report, MedPAC recommended a 2.8 percent positive update for physicians in 2007, and the College supports this recommendation

It is important to understand that in 2007 substantial changes to other components of Medicare payment formula will shift billions of dollars from certain specialties and practice types to others, which will lead to cuts of up to 10 to 12 percent for some physician services. It is essential that Congress act to provide a rational update to the conversion factor in order to bring some element of stability to an already turbulent system and to help alleviate the payment cuts caused by unrelated policy changes. The non-SGR related changes to physician payment in 2007 include:

### **1. Five-Year Review**

Every five years, CMS is required by law to comprehensively review all work relative value units (RVUs) and make needed adjustments. These adjustments must be made in a budget neutral manner. Changes related to the third five-year review will be implemented on January 1, 2007. In total, more than \$4 billion will be shifted to evaluation and management (E/M) codes alone, which will be increased by upwards of 35 percent in some instances. The \$4 billion needed to fund these increases is more than total Medicare physician spending on general surgery, cardiac surgery, neurosurgery, colorectal surgery and vascular surgery combined. In order to fund these increases, the work RVU of every code on the fee schedule will be reduced by an estimated 10 percent or there will need to be an additional 5 percent cut to the conversion factor. Because there are so many payment changes being implemented as a result of the five-year review, it is difficult to predict the exact impact on various specialties and services. Some services, including the E/M services, will receive overall increases in payment while others, including several key surgical codes, will receive reductions in addition to the budget neutrality adjustments being made because of changes in the time and intensity related to these codes. Further, codes that were not examined in the five-year review will be decreased between 3 and 6 percent to pay for the increases to the E/M codes. For example, if a code has the same value in the 2007 fee schedule as it did in the 2006 fee schedule, it will nonetheless be cut between 3 to 6 percent as a result of increases to other codes. These codes are not being cut because the work and intensity of the codes has changed, but instead are being cut to fund increases to other services in the budget neutral environment.

### **Practice Expense**

In its June 20 Notice of Proposed Rule Making, CMS announced significant changes to the formulas used to determine the practice expense RVUs. These changes are also budget neutral and will shift approximately \$4 billion to nine medical specialties. These increases will again be paid for by cuts to other specialties, most notably neurosurgery, orthopaedic surgery, ophthalmology, and cardiothoracic surgery.

### **3. Geographic Practice Cost Index (GPCI)**

The Medicare Prescription Drug, Modernization and Improvement Act of 2002 (MMA) included a three-year floor on work GPCI adjustments. Nationwide, 58 of the 89 physician payment areas received a 1 to 2 percent benefit from this provision, which will expire on December 31, 2006. Without the provision, certain providers, mainly in rural areas, will see their payments cut by an additional 1 or 2 percent.

This unprecedented and dramatic shift in the allocation of funding will have a remarkable impact on many physician practices across the country. The College is deeply concerned about the consequences of an SGR-imposed cut in conjunction with those that will result from a reallocation of funding and policy changes. While the total impact of the changes will vary by specialty, geographic location, and practice composition, physicians specializing in certain types of services could see cuts of up to 12 percent before any adjustments to the conversion factor are made as a result of the SGR. Almost all surgical services will receive cuts of 2 to 8 percent in 2007 as a result of these changes. To bring stability to the payment system, offset the reductions some specialties will experience, and maintain the increases granted to other specialties, ACS strongly encourages Congress to provide a positive update to the conversion factor for 2007.

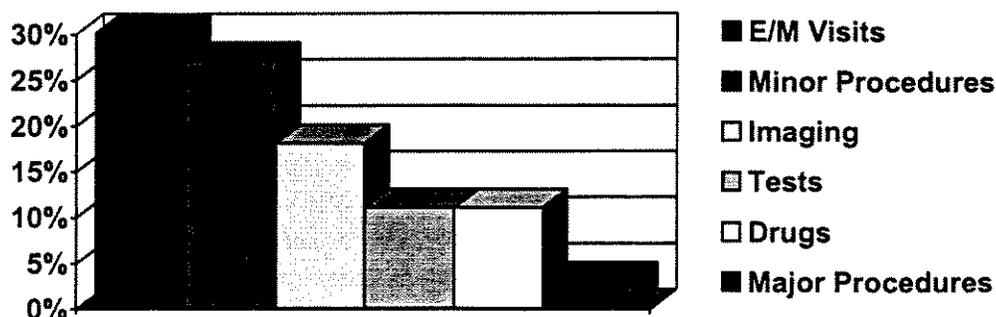
### **The Impact of the Current Payment Policy**

While it seems all policymakers agree there are problems with the SGR formula, what receives less attention is the devastating impact current payment policies are having on specific specialties and the patients they treat. For surgeons, reimbursements have declined exponentially since the inception of the Resource Based Relative Value System (RBRVS) in 1992 and the SGR in 1996. While some of these decreases are related to actual decreases in the time and intensity of a specific service due to advances in technology, many are not. In general, reimbursement policies have shifted billions of dollars from surgery to other medical specialties.

### **Volume Increases**

In the past five years, spending on Medicare physician services has increased between 7 and 14 percent per year. These increases are fueled by growth in the volume and intensity of E/M services, imaging, lab tests, physician-administered drugs, and minor procedures. However, volume for major procedures, those with a 10 or 90 day global period, have remained stagnant—growing by less than 2 percent a year. While other specialties have increased Medicare billings by increasing the volume of the services they provide, surgeons have not. It is much more difficult for surgeons to compensate for payment reductions by providing additional services or by seeing an individual patient more often. As a result, between 1998 and 2005, spending on major procedures and related anesthesia services dropped from 22 percent of total Medicare spending to less than 14 percent. While volume increases in certain areas are justified and can lead to better overall healthcare for beneficiaries, under the current payment system, surgeons are subsidizing these volume increases. For the short term at least, we can anticipate this problem of cross-subsidizing the cost care to become worse, as efforts to increase preventive care and better manage chronic conditions lead to further volume increases in non-surgical service categories,

## Components of Physician Spending Growth Increase 2003-04



### 2. Decreasing Reimbursements/Rising Costs

Since the inception of the Resource-based Relative Value Scale, reimbursement for many surgical procedures has been cut by more than 50 percent, before the effects of inflation are taken into account. At the same time, costs for providing services has increased and policies related to practice expense have shifted funds away from the surgical specialties. While the MEI is similar for all specialties, the surgical specialties have been impacted disproportionately by rising professional liability premiums. The average premium for surgeons is more than eight times that of other specialties, with certain surgical specialties like neurosurgery paying more than \$200,000 a year. Medicare reimbursement rates have not changed proportionately to reflect these changes in the market. A recent study from the Center for Studying Health System Change found that surgeons' income fell by 8.2 percent between 1998 and 2003 despite the fact that the time surgeons spent providing direct patient care increased by 6.2 percent during this same period, widening the gap between hours worked by surgeons and by other physician specialties. Also during that same period, overall professional income in the United States rose by more than 7 percent.

Service	1989 avg.	2006 avg.	2007 est.	% change
Cataract removal	\$1573	\$684	\$608	-61%
Total knee replacement	\$2301	\$1511	\$1314	-43%
TURP - prostatectomy	\$1139	\$695	\$738	-35%
Colectomy	\$1256	\$1226	\$1134	-10%
Laminectomy	\$2078	\$1051	\$962	-54%
Prostatectomy	\$3957	\$2049	\$2051	-48%
Prostatectomy	\$1051	\$997	\$958	-9%
Repair retinal detachment	\$2833	\$1375	\$1274	-55%
Craniotomy for hematoma	\$2018	\$1749	\$1677	-17%
Caesarian delivery	\$1038	\$1884	\$1814	75%
Office visit	\$31	\$53	\$60	94%

*2007 estimates based on CMS June 20, 2006 Notice of Proposed Rule Making*

### **3. Effects on Medicare Beneficiaries**

The effects of Medicare payment trends are being felt throughout the healthcare system. In May, the Institute of Medicine concluded in a series of reports entitled the *Future of Emergency Care* that many of the nation's emergency departments and trauma centers are experiencing shortages in the availability of on-call specialists. Surgeons provide lifesaving care to beneficiaries suffering from both traumatic injuries and medical emergencies. Patients suffering from strokes, blockages, and injuries often require timely treatment in order to prevent permanent disability or even death. Without the prompt availability of on-call surgeons, these beneficiaries do not receive the crucial care that they need.

In a report entitled *A Growing Crisis in Patient Access to Emergency Surgical Care*, ACS documented this phenomenon even further. The supply of surgeons has not kept pace with the patient population and a third of all practicing surgeons are nearing retirement age. Across the country, surgeons have reduced their call schedules and dropped or reduced risky or poorly paid services in order to maximize their time in the office.

Many medical students are avoiding a career in surgery all together. In 2006, only 60 percent of first-year surgical residency slots were filled and only 38 percent were filled with board-trained medical students. For some surgical specialties, including cardiac surgery, resident match numbers continue to plummet as medical students choose more lucrative specialties and those that offer more attractive lifestyles.

### **Reforming Medicare's Physician Payment System**

While, in the short term, ACS sincerely hopes that Congress will act to increase Medicare physician payments in 2007, the College just as strongly supports Medicare payment reform that yields a long-term solution to the future problems posed by the current Medicare physician payment system.

In addition to the immediate challenges posed to surgical care by the pending 4.7 percent cut and the upcoming fee schedule changes for 2007 outlined earlier, there are larger systemic challenges that seriously threaten Medicare beneficiaries' ability to access surgical care in the future. Nowhere was this reality more evident than in this year's Medicare Trustees Report, which was the first report to project nine straight years of cuts in Medicare physician reimbursement, totaling over 37 percent in cuts over that period.

This hearing, along with others held by the Health Subcommittee, demonstrates that the Medicare physician payment crisis is not lost on the Energy and Commerce Committee or on the Congress as a whole. The College greatly appreciates the efforts Committee Chairman Barton, Subcommittee Chairman Deal, Ranking Members Dingell and Brown, and the Committee staff have put forth to study how best to address the long-term challenges posed by the current structure. The College also greatly appreciates Dr. Burgess's recent introduction of the "Medicare Physician Payment and Quality Improvement Act of 2006" and believes his legislation furthers this effort by recognizing the need to replace the current structure with meaningful, lasting reforms.

The College also appreciates the support of this Committee and the Congress to avert Medicare cuts every year since 2003. Unfortunately, these temporary measures have not eliminated the challenges posed by the SGR, and creating a rational payment system that provides incentives for high-quality care and quality improvement is virtually impossible under the construct of Medicare's current physician payment system. That said, this does not mean that a rational payment system that provides incentives for quality care is unattainable, and we believe that a Medicare payment system that recognizes the unique nature of various physician specialties and services would bring the rational structure for comprehensive reform, including a structure that could more easily facilitate the move to a value-based purchasing system in which surgeons can participate.

One of the most irrational elements of the current method for determining physician reimbursement is the universal application of the volume and spending target imposed by the SGR. Even though the nature and type of services provided by different physician specialties often bear little resemblance to those provided by their colleagues in other specialties, the SGR subjects all specialties and services to an universal target on volume and spending that fails to recognize the unique nature of the care and services provided by the different specialties, or different degrees to which various specialties contribute to overall increases in Medicare physician spending. In addition to the obvious differences in the type of care provided by surgeons and other physicians, the services they provide are also billed differently. For example, surgical services are paid on a global basis, which means that, after the initial consultation, all pre- and post-operative care associated with a procedure (up to 90 days after the operation) is included in one payment bundle, regardless of complications or how many post-operative services are required.

With respect to service volume, for surgery generally--especially for major procedures--volume growth has been relatively inelastic, with volume growth averaging between 3 and 4 percent per year. In fact, in its recently released report on Medicare Physician Services, the General Accounting Office (GAO) found that from April 2001 to April 2005, the number of major procedures has declined by 3 percent. The GAO further found that volume generally increased for evaluation and management, minor procedures, imaging, and lab tests. There are several reasons for this inelastic growth in major procedures, including the fact that patients rarely self-refer to surgeons; rather, in most cases, surgeons only see patients after another physician has determined that a surgical assessment is needed. As a result, surgeons--along with other physicians who provide services with lower growth rates--bear a disproportionate cost of increased utilization of services they do not provide, regardless of whether or not that growth is justified. This difference in volume elasticity was recognized as far back as 1989, when the current payment system was initially constructed to include different volume growth targets for two, and later three, categories of service.

While the College, along with other physician organizations, has advocated for an elimination of the SGR expenditure target system, that remedy has been elusive for many reasons, not the least of which has been cost concerns. As a result, the College has developed an alternative proposal that we believe has the potential to solve, at least in part, many of the problems posed by the SGR, and has the potential to provide a rational structure that could serve as the basis for other reforms such as value-based purchasing. This proposal also enjoys the support of the American Osteopathic Association.

## The Solution – The Service Category Growth Rate

Our proposal would do the following:

- Replace the universal SGR volume target and replace it with a new system, known as the Service Category Growth Rate (SCGR) that recognizes the unique nature of different physician services by setting targets for six distinct categories of physician services, based on the Berenson-Eggers type-of-service definitions already used by CMS:
  - Evaluation and management services;
  - Major procedures (includes those with 10 or 90 day global service periods) and related anesthesia services;
  - Minor procedures and all other services, including anesthesia services not paid under physician fee schedule;
  - Radiology services and diagnostic tests;
  - Diagnostic laboratory tests; and
  - Physician-administered Part B drugs, biologicals, and radiopharmaceuticals.
- The SCGR target would be based on the current SGR factors (trends in physician spending, beneficiary enrollment, law and regulations), except that GDP would be eliminated from the formula and be replaced with a statutorily set percentage point growth allowance for each service category. To accommodate already anticipated growth in chronic and preventive services, we estimate that E/M services would require a growth allowance about twice as large as the other service categories (between 4 and 5 percent for E/M as opposed to somewhere between 2 and 3 percent for other services). Like the SGR, spending calculations under the SCGR system would be cumulative. However, the Secretary would be allowed to make adjustments to any of the targets as needed to reflect the impact of major technological changes.
- Like the SGR, the annual update for a service category would be the MEI plus the adjustment factor. But, in no case could the final update vary from the MEI by more or less than 3 percentage points; nor could the update in any year be less than zero.
- The Secretary could set aside up to one percentage point of the conversion factor for any service category for pay-for-performance incentive payments. In addition, different set aside percentages could be established for each service category.
- The SCGR would provide a framework for the development of value-based purchasing systems that are tailored to differences in the way various physician services are provided.

By recognizing the unique nature of different physician services, the SCGR would enable Medicare to more easily study the volume growth in different physician services and determine whether or not that volume growth is appropriate. In spite of the fact that the only area that many physicians have in common with their colleagues in other specialties is the fact that they are medical school graduates, for reimbursement purposes, Medicare treats all physicians to one global target for the services they provide, even though services often bear little resemblance to those provided by their colleagues. Like the SGR, the SCGR would

retain a mechanism for restraining growth in spending for physician services. It would also recognize the wide range of services that physicians provide to their patients. As a result, unlike the current universal target, which penalizes those services with low volume growth at the expense of high volume growth services, the SCGR would provide for more accountability within the Medicare physician payment system by basing reimbursement calculations on targets that compare like services, and providing a mechanism to more closely examine those services with high rates of growth without forcing low growth services to subsidize them, as is the case under the current system.

In addition, the SCGR would provide a framework for starting a basic value-based purchasing system. One of the ideas often floated among our meetings with policymakers is their desire to find a set of measures, a number between 3 and 5 is often mentioned, that broadly apply to all physicians. Given the diversity of physician services provided to patients, this is an almost impossible task. Yet, under the SCGR this task for measure development should be much easier since similar services will be compared. For example, in the case of major procedures, preoperative smoking cessation, measures for marking the surgical site, a surgical timeout, and appropriate post-operative follow-up could apply to most situations, and measuring for such processes could actually be meaningful in improving patient outcomes.

Mr. Chairman, thank you for providing the American College of Surgeons this opportunity to share with you the challenges facing surgeons under the Medicare program today. Whether the focus is on value-based purchasing or on the sustainable growth rate, the College looks forward to continuing to work with you to reform the Medicare physician payment system to ensure that Medicare patients will have access to the surgical care they need, and that the surgical care patients receive is of the highest quality.

## **Attachment A**

### **ACS History of Involvement in Quality Improvement Initiatives**

In 1918, the College initiated a Hospital Standardization Program in an effort to ensure a safe environment and effective system of care for surgical patients and others who are hospitalized. That program ultimately led to the establishment of what is known today as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). This commitment continues through the participation of three ACS JCAHO commissioners, as well as through other programs and initiatives conducted by College committees and programs.

#### **Commission on Cancer**

In 1922, the College established the multidisciplinary Commission on Cancer to set standards for high-quality cancer care. Today, the commission is comprised of more than 100 individuals representing more than 39 national professional organizations. Among other initiatives, the Commission on Cancer has established cancer program standards and conducted the accreditation of nearly 1,500 hospital cancer programs. It also provides clinical oversight for standard-setting activities and for the development and dissemination of patient care guidelines; and it coordinates national cancer site-specific studies on pattern of care and patient management outcomes through the annual collection, analysis, and dissemination of data for all cancer sites through the National Cancer Database (NCDB).

The NCDB is a nationwide, facility-based, oncology data set that currently captures 75 percent of all newly diagnosed cancer cases in the United States. The database currently holds 15 million cases of reported cancer diagnosis for 1985 through 2002. Data collected includes patient characteristics, tumor staging and characteristics, type of first course treatment, disease recurrence, and survival information.

#### **American College of Surgeons Oncology Group**

The American College of Surgeons Oncology Group (ACOSOG) was established in 1998, primarily to evaluate the surgical management of patients with malignant solid tumors. It includes general and specialty surgeons, representatives of related oncologic disciplines, and allied health professionals in academic medical centers and community practices throughout the U.S. and foreign countries.

The ACOSOG is one of 10 cooperative groups funded by the National Cancer Institute to develop and coordinate multi-institutional clinical trials and is the only cooperative group whose primary focus is the surgical management of patients with malignant solid tumors. Current clinical trials focus on tumors of the breast, melanoma, head and neck cancer, sarcoma and soft tissue tumors, thoracic tumors, and tumors of the central nervous, gastrointestinal, and genitourinary systems. ACOSOG's work will be vital to the development of future standards of care for the surgical management of trauma patients.

## **Committee on Trauma**

The Committee on Trauma (COT) develops the standards that most states employ to designate trauma centers. Since 1989, ACS has been addressing the need for a strong, national, trauma care system through development of the National Trauma Data Bank (NTDB). Designed by a collaborative group of COT members, emergency medical organizations, government agencies, and trauma registry vendors, the NTDB now contains over 1.5 million cases from 565 trauma centers. This data represents the largest aggregation of trauma care data ever assembled.

## **National Surgical Quality Improvement Program**

The National Surgical Quality Improvement Program (NSQIP) is the first nationally validated, risk-adjusted, outcomes-based program that has been demonstrated to accurately measure and improve the quality of surgical care. The program was initially developed by the Department of Veteran's Affairs (VA) in the early 1990s as an outgrowth of the National VA Surgical Risk Study. In the VA system, NSQIP had impressive results, with a 27 percent decline in post-operative mortality, a 45 percent drop in post-operative morbidity, a reduction in average post-operative length of stay from 9 to 4 days, and increased patient satisfaction. In 2001, the College developed its own NSQIP, which expanded the program to the private sector through a grant from the Agency for Healthcare Research and Quality.

The program employs a prospective, peer-controlled, validated database to quantify 30-day risk-adjusted surgical outcomes, allowing valid comparison of outcomes among the hospitals in the program. Medical centers and their surgical staffs are able to use the data to make informed decisions about their continuous quality improvement efforts. The program involves the following key components:

- Data Collection
- Data Monitoring
- Validation Report Generation
- Data Analysis

Of particular interest to hospitals is the generation of a risk-adjusted, observed-to-expected outcome ratio for each center, which can be compared to other participating centers on a blind basis. Statistical analysis of the pre-operative data identifies risk factors, and further analysis calculates the expected outcome for each hospital's patient population.

NSQIP involves a number of mechanisms to provide feedback to the participating hospitals and to the program as a whole. These mechanisms include annual data audits, site visits, and the sharing of best practices. This structured and careful feedback by program staff ensures the consistent reporting of data across sites and the rapid dissemination of information about successful surgical practices and the environments that produce the highest quality of care.

The College has expanded the NSQIP program to over 100 hospitals, including Partners HealthCare hospitals (the Harvard Medical School system). Many hospitals are in the queue for NQSIP adoption and are currently being added at a rate of five hospitals per

month. In 2002, the Institute of Medicine named the NSQIP “the best in the nation” for measuring and reporting surgical quality and outcomes.

### **Surgical Care Improvement Project**

The College is one of the 10 organizations on the Surgical Care Improvement Project (SCIP) steering committee. SCIP is a national partnership of organizations dedicated to improving the safety of surgical care by reducing post-operative complications. Its steering committee reflects the range of public and private organizations that must work together to reduce surgical complications, and includes groups representing surgeons, anesthesiologists, perioperative nurses, pharmacists, infection control professionals, hospital executives, and others who are working to improve surgical patient care.

The program was initiated in 2003 by the Centers for Medicare and Medicaid Services and the Centers for Disease Control and Prevention. This summer, the SCIP partnership will launch a multi-year national effort to reduce surgical complications by 25 percent by 2010.

SCIP quality improvement efforts are focused on reducing perioperative complications in the following four areas, where the incidence and cost of complications are significant:

- Surgical site infections
- Adverse cardiac events
- Venous thromboembolism
- Postoperative pneumonia

SCIP stresses that surgical care can be improved significantly through better adherence to evidence-based recommendations and increased attention to designing systems of care with thorough safeguards. Other evidence-based programs such as NSQIP, the National Nosocomial Infections Surveillance (NNIS) system, and the Medicare quality improvement organizations, have demonstrated this time and again. ACS is proud to play a leadership role in the development of the SCIP target areas, and our organization will continue to play a significant role in further developing SCIP initiatives.

### **ACS Bariatric Surgery Center Network Accreditation Program**

Recently, ACS developed a Bariatric Surgery Center Network (BSCN) Accreditation Program to foster high-quality care for patients undergoing bariatric surgery for morbid obesity. The program describes the necessary physical resources, human resources, clinical standards, surgeon credentialing standards, data reporting standards, and verification/approvals processes required for designation as a “bariatric surgery center.”

Severe obesity has reached epidemic proportions and because weight-reduction surgery provides an effective treatment for the condition -- and because the number of surgeons and hospitals providing this care has grown so quickly--the College decided to place a high priority on establishing this new accreditation program. The College contracts with hospitals and outpatient facilities that agree to implement this program and other resource standards by reporting outcomes data on all their bariatric surgery patients, submitting to site visits, and completing annual status reports. By reviewing existing studies

and consulting with experts in the field, ACS has developed standards, defined necessary resources, organized the means of collect data, and organized the processes for conducting site visits to accredit hospitals and outpatient facilities in order to improve patient safety.

### **Surgical Patient Safety: Essential Information for Surgeons in Today's Environment**

ACS has recently issued a patient safety manual titled *Surgical Patient Safety: Essential Information for Surgeons in Today's Environment*. This publication provides information and guidance for surgeons and others involved in surgical patient safety. It describes a variety of practical resources and provides a broad overview of key issues, such as the scientific basis of surgical patient safety.

Specifically, this manual analyzes the human factors, systems analyses, and processes affecting surgical patient safety. Issues such as decision-support, electronic prescribing, and error detection, analysis, and reporting are analyzed. Legal challenges for surgeon participation in patient safety activities are also reviewed. Broad error prevention methods such as the use of surgical simulation, educational interventions, and quality improvement initiatives are covered. In addition, the manual provides strategies for preventing wrong-site surgery and for safe blood transfusion and handling.

### **Surgical Quality Alliance (SQA)**

The SQA is a collaboration among specialty societies that provide surgical care to improve the quality of care for the surgical patient, to define principles of surgical quality measurement and reporting, and to develop awareness about unique issues related to surgical care in all settings. It has been an important avenue for education, discussion, and cooperation between surgical disciplines, as well as a means of participating in the multitude of quality efforts. At its first meeting in December 2005, SQA members developed four global process measures that were submitted to CMS on March 1 and June 1, 2006. In addition, the SQA has commented on National Quality Forum and AQA initiatives and continues to develop performance measures and reporting tools for surgery. The following specialty societies participate in the SQA:

- American Academy of Ophthalmology
- American Academy of Otolaryngology
- American Association for Hand Surgery
- American Association of Neurological Surgeons
- American Association of Orthopaedic Surgeons
- American College of Osteopathic Surgeons
- American College of Surgeons
- American Society of Anesthesiologists
- American Society of Breast Surgeons
- American Society of Cataract and Refractive Surgery
- American Society of Colon and Rectal Surgeons
- American Society of General Surgeons
- American Society of Plastic Surgeons
- American Urological Association
- Congress of Neurological Surgeons

- Society for Vascular Surgery
- Society of American Gastrointestinal Endoscopic Surgeons
- Society of Gynecologic Oncologists
- Society of Surgical Oncology
- Society of Thoracic Surgeons

## ATTACHMENT B

March 1, 2006

The Honorable Mark B. McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare and Medicaid Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Dr. McClellan:

A1 On behalf of the respective members of the undersigned societies representing specialties that provide surgical care, we are pleased to comment on the surgical measures included in the Physician Voluntary Reporting Program (PVRP) as announced by the Centers for Medicare and Medicaid Services (CMS) on October 28, 2005 and as modified on December 27.

We understand that in the current health care environment, performance measurements are based on administrative data. These data are collected for reimbursement purposes and, as shown by numerous studies, are a poor proxy for quality and performance measurements. The surgical community strongly supports quality initiatives and believes the need for clinical data to replace the current proxy is essential to a successful program. In addition, physicians who participate in national, recognized clinical databases should have a mechanism to submit clinical data instead of administrative data for performance measurement.

A2 Physician-specific performance measures defined by numerators, denominators, and inclusion and exclusion criteria represent a new means of capturing metrics. Our comments on the criteria in your proposal intend to better refine the codes to reflect a quality measure. For example, the use of CPT codes with 10-day and 90-day global categories is another option for the denominator, and could be an efficient means of organizing certain surgical measures. As your proposal currently stands, surgeons must keep a list of surgical procedures in front of them to know whether a procedure is subject to quality measures. A more global approach could enhance end-user acceptance and provide the added benefit that CMS does not have to go through the CPT annual update to identify and classify new CPT codes.

Instructions for the PVRP should specifically address what is to be displayed and/or left blank on the claim form. We request complete instructions for reporting Line 24, as there is a contradiction between current PVRP instructions and claim form instructions. For example, are place and type of service to be shown for PVRP line items? If so, are the same codes to be shown for the surgery? In addition, it is unclear if a G-code can be submitted on a supplemental form after the original claim has been submitted. There are two instances

when a supplemental G-code may be necessary, 1) the G-code is accidentally omitted from a claim form, or 2) the G-code does not occur at the same time as the corresponding procedure, as with discharge instructions.

With respect to PVRP participation, it is important to keep in mind that without funding, a high level of participation will likely be difficult to attain. Adding an administrative burden with a clinical interface represents a material change in the workflow of a clinical office. CMS should consider funding pilot programs in the next phase of the physician quality initiative.

We appreciate your efforts to engage physicians on issues of performance measurement and quality improvement and hope that our comments will improve the PVRP and surgical patient care.

## **SUGGESTED REVISIONS TO SURGERY-RELATED MEASURES**

The following are suggested revisions to surgery-related measures currently found in the PVRP.

### **1) Receipt of autogenous arteriovenous fistula in advanced chronic kidney disease patient and end-stage renal disease (ESRD) patient requiring hemodialysis**

*The current G-codes need to be expanded to include chronic kidney disease patients because a central goal of the Fistula First initiative is to place a native access in renal failure patients before they advance to ESRD. We also suggest that additional wording be added to verify that the G-codes be applied when the patient has undergone a non-catheter hemodialysis access operation. The proposed update:*

- *Allows for a more accurate representation of autogenous AV fistula use.*
- *Includes an exclusion code for patients who are not eligible for a fistula.*
- *Eliminates three CPT codes that are no longer relevant (36800, 36810 and 36815).*

#### **Proposed Update: Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis**

**GXXX1 (formally G8081):** Advanced chronic kidney disease patient or end-stage renal disease patient undergoing non-catheter hemodialysis vascular access documented to have received autogenous AV fistula.

**GXXX2 (formally G8082)** Advanced chronic kidney disease patient or end-stage renal disease patient requiring non-catheter hemodialysis vascular access documented to have received AV access using other than autogenous vein.

**GXXX3:** *Clinician documented that advanced chronic kidney disease patient or end-stage renal disease patient requiring hemodialysis vascular access was not an eligible candidate for autogenous AV fistula.*

Denominator: CPT codes 36818, 36819, 36820, 36821, 36825, and 36830 with ICD-9-CM codes 585.4, 585.5, and 585.6.

## 2) Antibiotic prophylaxis in surgical patient

The current measure includes the language, "patient documented to have received antibiotic prophylaxis" making this a hospital-based measure. The proposed update:

- More accurately measures a surgeon's performance by including the language "documentation in the medical record that surgeon ordered..."
- Expands the measure's applicability by including the use of antiseptics.
- Distinguishes between antibiotics/antiseptics not indicated for procedure and a medical or patient reason for not ordering antibiotics/antiseptics.
- Expands the denominator to include all non-emergency 10-day and 90-day global procedures.

### Proposed Update: Antibiotics or Antiseptics Ordered Prior to Incision

GXXX4 Documentation in the medical record that surgeon ordered prophylactic antibiotics or antiseptics be delivered within one hour of incision.

GXXX5 No documentation in the medical record that surgeon ordered prophylactic antibiotics or antiseptics be delivered within one hour prior to incision.

GXXX6 Documentation in the medical record of medical or patient's reason(s) for surgeon not ordering prophylactic antibiotics or antiseptics within one hour of incision.

GXXX7 Documentation in the medical record that prophylactic antibiotics or antiseptics are not indicated for procedure.

Denominator: All non-emergency 10-day and 90-day global procedures, and specified 0-day global procedures to be supplied by the American Academy of Otolaryngology.

## 3) Thromboembolism prophylaxis in surgical patient

With the antibiotic prophylaxis measure, this measure's current wording makes it more applicable to hospitals than physicians. The proposed update:

- More accurately measures a physician's performance by including the language "documentation in the medical record that surgeon ordered..."
- Distinguishes between DVT prophylaxis not indicated for procedure and a medical or patient reason for not ordering DVT prophylaxis.
- Expands the denominator to include all non-emergency 90-day global procedures.

### Proposed Update: DVT Prophylaxis

GXXX8 Documentation in the medical record that surgeon ordered appropriate DVT prophylaxis consistent with current guidelines.

GXXX9 No documentation in the medical record regarding appropriate DVT prophylaxis consistent with current guidelines.

GXX10 Documentation in the medical record of medical or patient's reason(s) for not ordering appropriate DVT prophylaxis consistent with current guidelines.

GXX11 Documentation in the medical record that DVT prophylaxis is not indicated for procedure.

Denominator: All non-emergency 90-day global procedures.

## **PROPOSED ADDITIONS TO THE PVRP**

The following are proposed surgery-related additions to the PVRP.

### ***1) Antibiotics or Antiseptics Administered Prior to Incision***

In the case of prophylactic antibiotics or antiseptics prior to incision, it is not only important to measure whether the service was ordered by the surgeon, but also to measure the administration of the prophylactic antibiotics or antiseptics by the anesthesiologist or other physician.

Numerator:

GXX12 Documentation in the medical record that anesthesiologist or other appropriate provider administered prescribed prophylactic antibiotics or antiseptics within one hour prior to incision (within two hours for vancomycin).

GXX13 No documentation in the medical record that anesthesiologist or other appropriate provider administered prescribed prophylactic antibiotics or antiseptics within one hour of incision (two hours for vancomycin).

GXX14 Documentation in the medical record that prophylactic antibiotics or antiseptics were not ordered for the procedure.

Denominator: All non-emergency 10-day and 90-day global procedures and anesthesia CPT codes 00100-01995 and 01999.

### ***2) Cardiac Risk, History, Current Symptoms and Physical Examination - Surgeon***

Adverse cardiac events occur in 2-5 percent of patients undergoing non-cardiac surgery and in 34 percent of patients undergoing vascular surgery. The National Quality Forum (NQF) *Safe Practices for Better Healthcare* includes an evaluation of each patient undergoing non-emergency surgery for risk of an adverse cardiac event.

Numerator:

GXX15 Documentation in the medical record that the surgeon assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX16 Documentation in the medical record that surgeon received a cardiac risk assessment from an appropriate provider.

GXX17 No documentation in the medical record that the surgeon or other appropriate provider assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX18 Documentation in the medical record that history of conditions associated with elevated cardiac risk could not be obtained.

Denominator: All non-emergency 10-day and 90-day global procedures.

### 3) *Cardiac Risk, History, Current Symptoms and Physical Examination - Anesthesiologist*

Both the surgeon and anesthesiologist's cardiac risk assessment are vital to the safety of the patient. Both physicians should be able to report a cardiac risk assessment g-code.

Numerator:

GXX19 Documentation in the medical record that anesthesiologist assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX20 Documentation in the medical record that anesthesiologist received a cardiac risk assessment from an appropriate provider.

GXX21 No documentation in the medical record that the anesthesiologist or other appropriate provider assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX22 Documentation in the medical record that history of conditions associated with elevated cardiac risk could not be obtained.

Denominator: Anesthesia CPT codes 00100-01995 and 01999.

### *Preoperative Smoking Cessation*

Smoking cessation measures have been endorsed by various quality organizations including the NQF, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Physician Consortium for Performance Improvement (PCPI) for patients with specific disorders.

Smoking prior to surgery can lead to increased incidence of wound complications, diminished vascularity and poor wound healing.

Numerator:

GXX23 Documentation in the medical record that surgeon provided patient with information on the benefits of preoperative smoking cessation.

GXX24 No documentation in the medical record that surgeon provided patient with information on the benefits of preoperative smoking cessation.

GXX25 Documentation in the medical record that patient does not smoke.

Denominator: All non-emergency 90-day global procedures.

### *Wrong-Side, Wrong-Site, Wrong-Person Surgery Prevention*

Wrong-side, wrong-site, wrong-person surgery is included in NQF's *Serious Reportable Events in Healthcare* and *Safe Practices for Better Healthcare*. Though JCAHO introduced the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery in July 2004, problems still exist. Between September 30, 2004 and September 30, 2005, 62 new cases of wrong-side, wrong-site, and wrong-person surgery were reported to JCAHO's Sentinel Event Database. We believe it is important to use every means possible, including quality programs, to prevent wrong-side, wrong-site, and wrong-person procedures.

Numerator:

X26 Documentation in the medical record that surgeon participated in a "time out" with members of the surgical team to verify intended patient, procedure, and surgical site.

X27 No documentation in the medical record that surgeon participated in a "time out" with members of the surgical team to verify intended patient, procedure, and surgical site.

Denominator: All non-emergency 10-day and 90-day global procedures.

#### *6) Patient Copy of Preoperative Instructions*

The NQF and the American Medical Association have written about the adverse events that occur when patients are not fully informed. We believe that patients should be given a copy of preoperative instructions that can be taken home, easily referred to, and shared with appropriate family, friends, and caregivers.

Numerator:

X28 Documentation in the medical record that surgeon gave, or directed staff to give, a copy of preoperative instructions to the patient.

X29 No documentation in the medical record that surgeon gave, or directed staff to give, a copy of preoperative instructions to the patient.

Denominator: All non-emergency 10-day and 90-day global procedures.

#### *7) Patient Copy of Postoperative Discharge Instructions*

JCAHO, NQF, and CMS have endorsed measures for discharge instructions for heart failure patients. We believe that discharge instructions should be given to all surgical patients as a means of educating the patient and their family about activity level, diet, discharge medications, proper incision care, symptoms of a surgical site infection, what to do if symptoms worsen, and follow-up appointments.

Numerator:

X30 Documentation in the medical record that surgeon provided, or directed staff to provide, written discharge instructions that address all of the following: activity level, diet, discharge medications, proper incision care, symptoms of surgical site infection, what to do if symptoms worsen, and follow-up appointments.

GXX31 No documentation in the medical record that surgeon provided, or directed staff to provide, written discharge instructions.

GXX32 Patient died prior to discharge.

Denominator: All 10-day and 90-day global procedures.

Thank you again for the opportunity to comment on the PVRP and for your efforts to improve the quality of our nation's healthcare. Please do not hesitate to contact us with any questions or concerns.

Sincerely,

**American Academy of Ophthalmology  
American Academy of Otolaryngology  
American Association of Neurological Surgeons  
American Association of Orthopaedic Surgeons  
American College of Osteopathic Surgeons  
American College of Surgeons  
American Society of Anesthesiologists  
American Society of Cataract and Refractive Surgery  
American Society of General Surgeons  
American Society of Plastic Surgeons  
American Urological Association  
Congress of Neurological Surgeons  
Society for Vascular Surgery  
Society of Thoracic Surgeons**

cc: Trent Haywood, JD, MD

June 1, 2006

The Honorable Mark B. McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare and Medicaid Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Dr. McClellan:

On behalf of the respective members of the undersigned societies representing specialties that provide surgical care, we appreciate the opportunity to expand on our March 1, 2006 letter, as well as previous meetings and calls, regarding the Centers for Medicare and Medicaid Services' (CMS) Physician Voluntary Reporting Program (PVRP). After reviewing the latest version of the PVRP (effective April 1), it is clear that the comments of the surgical community have not been incorporated into the program.

While we understand your interest in the measures being developed in the Physician Consortium for Performance Improvement (PCPI) and have been actively involved in that effort, we also understand that measures from the Perioperative Workgroup will not be finalized for many months. As your office has stated, the PVRP offers physicians an opportunity to report on performance measures as a "trial run". Unfortunately, many specialties, including plastic surgery, ophthalmology and anesthesiology are unable to participate because 1) the current measures do not relate to their specialty or 2) applicable specialty procedure codes are not included in the measure's denominator.

It is vital that physician measures represent physician activities. As stated by the PCPI, performance measures should be "potentially actionable by the user. The measure (should) address an area of health care that (is) potentially under the control of the physician, health care organization or health care system that it assesses." Hospital-level measures should not be used to measure physician performance.

On many occasions, CMS has stated that the current measure set has been through a consensus development process. Unfortunately, the PVRP contains hospital-level, surgical measures that have not been vetted for physician measurement, including the antibiotic and prophylaxis measures.

While we appreciate your efforts to engage physicians on issues of performance measurement and quality improvement, it is also important to recognize quality efforts already in use. Specialty societies collecting clinical data should be allowed to use that data for quality improvement programs, including the PVRP. Clinical data is superior in measuring quality and should be used instead of administrative data when available.

It is our understanding that the first quarter of the PVRP will end June 30, with the second quarter running from July 1 through September 30. In addition, we understand that significant lead time is required for implementation and therefore ask that our proposed changes and additions be reviewed for incorporation into the program for the third quarter

Beginning October 1, 2006 to ensure the entire surgical community has the option of voluntary participation.

Thank you again for the opportunity to comment on the PVRP. We hope that our comments will improve the program and care for the surgical patient.

## **DENOMINATOR CHANGES NEEDED**

The current surgical codes included in the antibiotic and VTE prophylaxis denominators need to be reviewed for accuracy. An example of current problems with the DVT Measure Denominator is below.

47133 – Donor Hepatectomy, (including cold preservation), from cadaver donor. DVT prophylaxis does not need to be received by a cadaver.

Developing denominators for performance measures that traverse many surgical specialties is a daunting task complicated by a paucity of reasonable evidence. For example, numerous common clinical practices do not address proper antibiotic or venous thromboembolism prophylaxis in surgery. In order to promote buy-in to the entire quality initiative, the surgical specialty societies and the American Society of Anesthesiologists are currently reviewing the evidence and guidelines for procedures in which antibiotic and venous thromboembolism prophylaxis are indicated. The societies will build consensus on codes for inclusion in these measures. During this process, societies are examining families of codes in addition to single codes from the family that may be appropriate for inclusion in the denominators. The Surgical Quality Alliance will provide a list of codes and will periodically update the list to maintain current measures.

## **SUGGESTED REVISIONS TO SURGERY-RELATED MEASURES**

The following are suggested revisions to surgery-related measures currently found in the PVRP.

**Receipt of autogenous arteriovenous fistula in advanced chronic kidney disease patient and end-stage renal disease (ESRD) patient requiring hemodialysis**

### **Proposed Update**

GXXX1 (formerly G8081): Advanced chronic kidney disease patient or end-stage renal disease patient undergoing non-catheter hemodialysis vascular access documented to have received autogenous AV fistula.

GXXX2 (formerly G8082) Advanced chronic kidney disease patient or end-stage renal disease patient requiring non-catheter hemodialysis vascular access documented to have received AV access using other than autogenous vein.

GXXX3: Clinician documented that advanced chronic kidney disease patient or end-stage renal disease patient requiring hemodialysis vascular access was not an eligible candidate for autogenous AV fistula.

Denominator: CPT codes 36818, 36819, 36820, 36821, 36825, and 36830 with ICD-9-CM codes 585.4, 585.5, and 585.6.

## 2) Antibiotic prophylaxis in surgical patient

### Proposed Update

GXXX4 Documentation in the medical record that surgeon ordered prophylactic antibiotics be delivered within one hour of incision.

GXXX5 No documentation in the medical record that surgeon ordered prophylactic antibiotics be delivered within one hour prior to incision.

GXXX6 Documentation in the medical record of medical or patient's reason(s) for surgeon not ordering prophylactic antibiotics within one hour of incision.

GXXX7 Documentation in the medical record that prophylactic antibiotics are not indicated for procedure.

## 3) Venous thromboembolism (VTE) prophylaxis

### Proposed Update

GXXX8 Documentation in the medical record that surgeon ordered appropriate VTE prophylaxis consistent with current guidelines.

GXXX9 No documentation in the medical record regarding appropriate VTE prophylaxis consistent with current guidelines.

GXXX10 Documentation in the medical record of medical or patient's reason(s) for not ordering appropriate VTE prophylaxis consistent with current guidelines.

GXXX11 Documentation in the medical record that VTE prophylaxis is not indicated for procedure.

### PROPOSED ADDITIONS TO THE PVRP

The following are proposed surgery-related additions to the PVRP.

#### **1) Antiseptics Ordered Prior to Incision**

*GXXX4 Documentation in the medical record that surgeon ordered prophylactic antiseptics be delivered within one hour of incision.*

*GXXX5 No documentation in the medical record that surgeon ordered prophylactic antiseptics be delivered within one hour prior to incision.*

*GXXX6 Documentation in the medical record of medical or patient's reason(s) for surgeon not ordering prophylactic antiseptics within one hour of incision.*

*Denominator: 66830, 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984, 66985, 66986.*

#### **Antibiotics Administered Prior to Incision**

GXXX12 Documentation in the medical record that anesthesiologist or other appropriate provider administered prescribed prophylactic antibiotics within one hour prior to incision or within two hours for vancomycin (from start time if no incision is required).

GXXX13 No documentation in the medical record that anesthesiologist or other appropriate provider administered prescribed prophylactic antibiotics within one hour of incision or within two hours for vancomycin (from start time if no incision is required).

GXX15 Documentation in the medical record that prophylactic antibiotics were not ordered for the procedure.

GXX17 Documentation in the medical record that prophylactic antibiotics are not indicated for the procedure.

Denominator: Anesthesia CPT codes 00100-01995 and 01999.

### **3) Cardiac Risk, History, Current Symptoms and Physical Examination - Surgeon**

GXX15 Documentation in the medical record that the surgeon assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX16 Documentation in the medical record that surgeon received a cardiac risk assessment from an appropriate provider.

GXX17 No documentation in the medical record that the surgeon or other appropriate provider assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX18 Documentation in the medical record that history of conditions associated with elevated cardiac risk could not be obtained.

Denominator: 10-day and 90-day global procedures.

### **Cardiac Risk, History, Current Symptoms and Physical Examination - Anesthesiologist**

GXX19 Documentation in the medical record that anesthesiologist assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX20 Documentation in the medical record that anesthesiologist received a cardiac risk assessment from an appropriate provider.

GXX21 No documentation in the medical record that the anesthesiologist or other appropriate provider assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX22 Documentation in the medical record that history of conditions associated with elevated cardiac risk could not be obtained.

Denominator: Anesthesia CPT codes 00100-01995 and 01999.

### **Preoperative Smoking Cessation**

GXX23 Documentation in the medical record that surgeon and/or anesthesiologist provided patient with information on the benefits of preoperative smoking cessation.

GXX24 No documentation in the medical record that surgeon and/or anesthesiologist provided patient with information on the benefits of preoperative smoking cessation.

GXX25 Documentation in the medical record that patient does not smoke.

GXX26 Documentation of emergency surgery that did not allow preoperative smoking cessation.

Denominator: 90-day global procedures.

**Wrong-Side, Wrong-Site, Wrong-Person Surgery Prevention (Time-Out)**

GXX26 Documentation in the medical record that surgeon participated in a "time out" with members of the surgical team to verify intended patient, procedure, and surgical site.

GXX27 No documentation in the medical record that surgeon participated in a "time out" with members of the surgical team to verify intended patient, procedure, and surgical site.

Denominator: 10-day and 90-day global procedures.

**7) Patient Copy of Preoperative Instructions**

GXX28 Documentation in the medical record that surgeon gave, or directed staff to give, a copy of preoperative instructions to the patient.

GXX29 No documentation in the medical record that surgeon gave, or directed staff to give, a copy of preoperative instructions to the patient.

GXX26 Documentation of emergency surgery that did not allow for preoperative instruction.

Denominator: 10-day and 90-day global procedures.

**8) Patient Copy of Postoperative Discharge Instructions**

GXX30 Documentation in the medical record that surgeon provided, or directed staff to provide, written discharge instructions that address all of the following: activity level, diet, discharge medications, proper incision care, symptoms of surgical site infection, what to do if symptoms worsen, and follow-up appointments.

GXX31 No documentation in the medical record that surgeon provided, or directed staff to provide, written discharge instructions.

GXX32 Patient died prior to discharge.

Denominator: 10-day and 90-day global procedures.

Thank you again for the opportunity to comment on the PVRP and for your efforts to improve quality of our nation's healthcare. Please do not hesitate to contact Julie Lewis at the American College of Surgeons ([jlewis@facs.org](mailto:jlewis@facs.org) or 202.672.1507) with any questions or concerns.

Sincerely,

**American Academy of Ophthalmology  
American Academy of Otolaryngology – Head and Neck Surgery  
American Association of Neurological Surgeons  
American Association of Orthopaedic Surgeons  
American College of Osteopathic Surgeons  
American College of Surgeons  
American Society of Anesthesiologists  
American Society of Cataract and Refractive Surgery  
American Society of Colon and Rectal Surgeons  
American Society of General Surgeons  
American Society of Plastic Surgeons  
American Urological Association  
Congress of Neurological Surgeons  
Society for Vascular Surgery  
Society of American Gastrointestinal Endoscopic Surgeons  
Society of Thoracic Surgeons**