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Re: Global Surgical Services Survey

Dear Drs. Gidengil and Mulcahy:

On behalf of the undersigned 19 organizations, we are writing to voice our deep concerns with the Global Surgical Services Survey developed by RAND Corporation (RAND). Based on our review, we find this version of the survey fundamentally flawed as a means to collect useful information about the time, staff, and resources involved in furnishing postoperative visits and other services included in global surgical payment. We further detail the flaws in the survey below, but generally speaking, it is overly complex, time consuming, and difficult to complete. The survey should also be reorganized to make it easier for physicians to respond. In addition, specific questions must be rewritten to improve the structure and clarity of the questions. In additional areas, there must be complete deletions because questions include incorrect information or do not relate at all to the level of postoperative visits.

Use of the current survey will yield data that will make it impossible to accurately validate postoperative work values for specific procedures. **We urge RAND to suspend use of the survey in its current form; rather the survey should be revised to capture relevant information about postoperative visits using a format that is clear, straightforward, and logical. The survey should be directly related to capturing data on postoperative visits and should impose the least possible burden on the physicians in the survey sample.**

It is critical that clinical experts from the specialties who will be surveyed have the opportunity to provide feedback, so we appreciate that RAND has provided us an opportunity to preview this survey. In this letter, we provide feedback on various aspects of the survey, organized as follows:

- **Background**
- **Overall study design concerns**
    - Reporting on consecutive patients
    - Expected survey response rate
    - Length of survey

    - Difficulty with completing the form
    - Survey validation
- **Questions that should be reorganized**
    - Questions related to procedure codes and modifiers
    - Face-to-face and non-face-to-face questions
    - Questions related to work between or after visits
- **Confusing terminology and concerns with specific questions**
    - Confusing/incorrect terminology
    - Irrelevant questions to be deleted
    - Confusing/incorrect answer choices
    - Confusing/difficult to answer questions
- **Conclusion**

BACKGROUND

Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the Centers for Medicare & Medicaid Services (CMS) to use rulemaking to obtain information, starting January 1, 2017, from a representative sample of physicians to access the accuracy of the valuation of surgical services. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery, as appropriate. Beginning in 2019, the information collected, along with any other available data, must be used to improve the accuracy of the valuation of surgical services.

In the calendar year (CY) 2017 Medicare Physician Fee Schedule final rule, CMS indicated that it planned to use a practitioner survey, in addition to claims-based data reporting, to comply with the MACRA requirement to collect data on global codes. The rule described a plan to sample practitioners, rather than specific procedures or visits, in an attempt to streamline survey data collection and minimize respondent burden. CMS stated in the final rule that the Agency expects a response rate in excess of 50 percent. CMS did not propose that respondents report on the entire period of postoperative care for individual patients, because the Agency considers a 90-day follow-up window (in cases of 90-day global codes) more burdensome to practitioners. Instead, CMS stated that it planned to collect information on a range of different postoperative services resulting from surgeries furnished by the in-sample practitioner prior to or during a fixed reporting period. CMS stated that the survey approach is intended to complement the claims data collection by collecting detailed information on the activities, time, intensity, and resources involved in delivering global services. The resulting visit-level survey data are intended to allow CMS to explore in detail the variation in activities, time, intensity, and resources associated with global services within and between physicians and procedures and are intended to validate the information gathered through claims.

OVERALL STUDY DESIGN CONCERNS

Reporting on consecutive patients

RAND indicates that a survey should be completed for every consecutive visit that is part of a 10- or 90-day global period (regardless of payer) until the physician reaches a total of 10 visit

surveys. The surveys will not be consecutive visits for the same patient following a specific procedure with a global period; rather, the survey will capture consecutive visits for different patients over the course of the physician's day (or days) until 10 visit surveys related to 10- or 90-day global codes are completed.

This survey design will not yield usable data for accurate valuation of individual CPT codes. As currently constructed, this approach will result in a broad range of responses with too few to draw reliable conclusions about the postoperative visits for any single CPT code. This is particularly true for those surgical specialties that perform a wide variety of procedures, such as general surgery. For example, a typical general surgeon regularly performs over one to two hundred 10- or 90-day global services. Thus, feedback from respondents will result in a jigsaw puzzle of data on disparate procedures from various points in the postoperative period, and it will be challenging to piece together an accurate picture of the range of services provided over the course of the postoperative visits for a given procedure. In other words, only a very large number of survey responses would produce statistically significant results for any one CPT code. However, based on the CY 2017 PFS final rule, CMS anticipates receiving approximately 5,000 responses from all postoperative visits on all codes from all specialties. It will not be appropriate to draw conclusions on how to revalue specific global codes from such a small sample size. **The current format that requires 10 surveys on consecutive visits is one of the most serious flaws of the Global Surgical Services Survey, and we urge RAND to reconsider this aspect of the survey design.**

Expected survey response rate

To expand on the points made above, much of the information that is being collected in the survey would need a very large number of responses to gather statistically significant data. The proposed rule indicates that approximately 9,000 practitioners (of all specialties) will receive a Global Surgical Services Survey, and that RAND expects approximately 5,000 responses. We believe that this is a gross overestimation of the expected response rate. For example, in the case of American Medical Association/Specialty Society Relative Value Update Scale Committee (RUC) surveys, which are far easier to complete, there is typically a response rate of less than 5 percent. In addition, neither CMS nor RAND have indicated what practice types will receive the survey. When determining the survey sample, we urge that RAND mirror national practice types (employed, academic, rural community, single, and multispecialty).

We are also concerned that a lack of education and/or dissemination of information about the survey process will further undermine the participation rate. In conversation, RAND has stated that physician education on the survey is not planned and that it is intended for physicians to receive and complete the survey without prior outreach. This strategy will make it even less likely that RAND will receive sufficient responses. **We consider the lack of education a serious design flaw and urge RAND to reconsider the number of surveys that will be sent out and the need for prior education.**

Length of survey

Another obstacle to the survey's success is its length and the time required to complete it. The introduction to the survey indicates that a physician is required to complete 10 surveys (one for each of 10 patients seen consecutively), in addition to providing practice information at the end of the 10 surveys. RAND estimates that the survey will take 10-15 minutes per patient with 8 minutes at the end for the practice information portion, for a total of 1.8 to 2.6 hours. **We have consulted with surgeons who have attempted to complete the draft survey, and it is clear that that the times offered by RAND are a gross underestimation of the amount of time it takes to complete the survey**. Specifically, it has taken our reviewers up to 30 minutes to enter the required information for **each** patient, in addition to 30 minutes to complete the practice information section. These surgeons understand the purpose of the survey and are experienced in coding and reimbursement. Those with no prior knowledge of the survey will likely take even longer. In addition to the inaccurate time estimates offered by RAND, physicians simply do not have this much time to complete the survey without planning to reschedule a lighter clinic load over one or more days. We cannot stress enough that the length and time required is much greater than RAND has suggested, and therefore will be one of the biggest barriers to physicians fully completing the survey. **The survey should be shortened and tailored to focus only on the information relevant to the level of postoperative visits, and should provide a more realistic estimate of the time required to complete so that physicians can plan accordingly.**

Difficulty with completing the form

As currently presented, it is difficult for physicians to enter information into the survey form. The survey format only allows one screen of the survey to be viewed at any given time. This "SurveyMonkey" approach can be appropriate for simple surveys where each question can be answered discretely. In contrast, the Global Surgical Services Survey is more complex and some early questions have bearing on later questions. For this type of survey it is extremely difficult to answer the questions without being able to view the survey as a whole. It is also cumbersome to complete the survey online when the computer that is being used for the survey also must be used to find information to complete the survey. This will require switching back and forth between screens to obtain some information. Our reviewers also had difficulty navigating between different questions within the survey to edit or verify that information was complete and consistent. For example, if some information is not readily available, the respondent should be able to skip ahead and fill out the information that is readily known. For these reasons, **it is critical that RAND provide the survey in a format that can be reviewed all at once, preferably as a multipage form similar to a Word document where scrolling up and down is allowed before submission. It is also imperative that RAND create a print function for the survey so the respondent has a record of what was submitted.**

Survey validation

We urge RAND to develop a methodology to validate the information that was provided by the survey respondents. Our reviewers were familiar with the information collection mandate, yet still found the survey questions poorly phrased and/or confusing. After completing the survey and after group discussion with RAND, our reviewers realized they had misinterpreted

some questions and provided incorrect responses. For example, one reviewer misunderstood that a survey was to be completed for each of 10 consecutive postoperative visit patients and instead provided information about the first postoperative visit for ten consecutive patients. Another reviewer included information on facility clinical staff services, despite the fact that facility staff are paid through facility fees and not through the physician's practice, and therefore would not be relevant to the valuation of global codes. **Without survey validation, there will be uncertainty as to whether the data and other observations drawn from the survey results will be accurate. We only support use of data that are demonstrated to be valid to assess the accuracy of resource inputs for global codes.**

QUESTIONS THAT SHOULD BE REORGANIZED

The order of survey questions and organization of some of the questions themselves are not coherent. Some of the requested information might be available in the patient medical record, and some information will need to be collected by other means, for example through the billing department or query of clinical staff. This creates a disjointed survey completion process where respondents will be required to stop midway through the survey because information is not readily available. Instead, the questions should be organized in a way that aligns with the availability of information and normal thought process for providing this information. Examples are provided below.

Questions on procedure codes and modifiers related to the visit

This question is included in the survey to collect information about procedure codes (and modifiers) related to the postoperative global code visit.

- ***"What was the procedure that prompted this visit? (Please enter a procedure with a 10- or 90-day global period. If multiple procedures prompted the visit, you will be given the opportunity to list these procedures later.)"***

First, procedures do not "prompt" postoperative visits; rather postoperative visits are related to procedures and services. Second, we recommend that the date of surgery be requested to confirm that the visit is within the global period for the procedure code(s). This is important because many surgeons, especially those that are new in practice or work in an employed environment may not know the global period of the procedures that they perform. Third, only two modifiers are allowed and anatomical modifiers are not allowed at all. We recommend that more modifiers, beyond just two, be allowed and that anatomical modifiers may be reported as well. Anatomical modifiers are relevant in cases where procedures can be reported in multiples, for example, repair of tendon in two fingers on one hand or one finger on both hands. In such cases, the postoperative visits would not be duplicated, but the work of dressing changes, therapy orders etc., will be greater at each visit for two hands versus one hand. **Disallowing anatomical modifiers would result in losing this information that is relevant to the services provided during the postoperative visit and causes us great concern as to why a survey that purports to seek data for accurate valuation of services would not be interested in capturing this information.** Fourth, the survey should request all of the CPT codes reported, not just the 10-

and 90-day global codes, to provide a more complete picture of the procedures and services provided during the operation.

We suggest that the questions related to dates and reported procedure codes/modifiers be reorganized as described in the box below so that the respondent will be able to accurately describe the relationship of procedures/services with postoperative work:

Please enter the date of surgery and all CPT codes(s) and modifier(s) that were submitted for payment for the operation that is related to this office visit.

Date of Surgery: *<insert calendar selection tool>*

CPT code 1: *<insert CPT code dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*

CPT code 2: *<insert CPT code dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*

CPT code 3: *<insert CPT code dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*

CPT code 4: *<insert CPT code dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*

CPT code 5: *<insert CPT code dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*
Modifier: *<insert surgical modifier dropdown box>*

Did you submit more than 5 CPT codes for the operation related to this postoperative visit?

- o *Yes*
- o *No*

Date of this postoperative <office / facility> visit: *<insert calendar selection tool>*

Please note that the surgical code(s) and modifier(s) related to the visit are not typically included in the patient's chart and may not be available on any screen that the physician can access on their office computer. Also, most surgeons may not have a solid grasp of modifiers that their practice billing departments may apply, even if they knew the one or two procedure codes that would apply. To complete these questions, the physician would be required to contact their practice manager or the practice billing department to request the procedure codes and modifiers submitted for payment. As such, the questions above should be moved to the beginning of the survey and should be allowed to be bypassed, if necessary, until the information is collected. This way the physician can complete the survey and then later obtain procedure codes and modifiers for all survey patients at once from their billing department, as needed.

In addition, for early postoperative visits, it is possible that the payment coding information may not be available if the claim has not yet been prepared for submission. It is also possible that one or more of the codes may be denied by the payer several months later, which is information the RAND survey will not be able to capture. Finally, it is possible that physicians will enter code and modifier information based on their perception of what should be reported and not confirm what was correctly reported or what was actually accepted by the payer. For these reasons, it will be difficult to collect procedure and modifier code information via this survey methodology, and any data that are collected will not be possible to verify.

Also, for this particular question, one of our reviewers attempted to add a 90-day code (60240, *Thyroidectomy, total or complete*) but the code did not appear in the drop down list of selections, so could not be added. If some but not all 10- and 90-day codes are able to be added as procedures related to the visit, then instructions should be included on how to handle procedures that are not found on the drop down list. If the intent of the survey is to allow all 10- and 90-day codes to be added as procedures related to the visit, then this lack of thoroughness should be corrected.

Face-to-face and non-face-to-face questions

The questions that address face-to-face (FTF) and non-face-to-face (non-FTF) activities and time are organized poorly in the current survey. There are several questions on this issue, but these questions should instead be combined into one question and placed on a single page and into one table. The example table below captures information from several of the survey questions, which should be combined into one request because reporting this information is part of a single thought process. **We urge RAND to revise the questions on FTF and non-FTF activities using this table as a guide:**

		You Personally (minutes)	**Your NP/PA (minutes)**	**Your Resident (minutes)**	**Other Clinical Staff (minutes)**	**Not Performed**
Activity	face-to-face					
	non-face to face					

Work between or after visits

The following two questions are included in the survey to collect information about work performed between visits or after the survey visit:

- ***"Now we'd like to learn more about the work that sometimes takes place in between visits. Please select the activities below that you personally performed between the last time you or another practitioner in your practice saw this patient and this visit. Please do not include any activities performed on the day of this visit."***

- ***"Based on your past experience, please select the non-face-to-face activities (which could include those done via phone or patient portal) that you personally expect to perform after this visit but before either the next anticipated visit or the end of global period (whichever comes first.) Please do not include any activities performed on the day of the visit of interest."***

We are concerned that the survey implies that work "on the day of the visit" is completely distinct from work "between/after visits." Every physician has his or her own personal approach to visit-related activities. Some physicians might perform certain activities on the day of the visit, while others might perform the same activities the day before or day after the visit. For example, an orthopedic surgeon may review a patient's chart the day before the visit and add an order for an x-ray or an ophthalmologist may review a patient's chart the day before the visit and add an order for an eye scan. In the offices where the review of the records or other activity is done "on the day" of the visit, these activities would be considered as non-FTF work. However, in cases where the work is done on the day before (i.e., between visits), it is considered different work, which is not clearly differentiated in this question.

Similarly, some post-visit work such as contacting another provider; work related to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); or home health orders can be done on the day of the office visit if time permits, or may be done the next day if, for example, the physician is called to another surgery. The mutually exclusive distinctions in the RAND survey assume that no work directly related to the survey visit was necessary "on the day of the visit" if it were not actually done that day. This is incorrect because the same work could be done on a different day.

An example of the lack of a clear bright line between what is considered work "between visits" versus what is considered work "after visits" is the review of lab results or images. These results/images can be reviewed three weeks before the current visit as post-work from the previous visit, but then reviewed again the day of the current visit as pre-work to the current visit. From a quality standpoint, the review in both instances is necessary to avoid a host of complications or inappropriate treatments. We do not understand the need for this distinction. The relevant questions are whether the work was done, who did the work, and how long the activity took. This is the information that the RAND survey should seek to collect.

Activities that are considered integral to the visit should encompass everything that is related to the visit, including all work before, during, and after, and should not be limited to the day of the visit. **RAND should revise the questions related to capturing work directly related to the survey visit versus work between or after visits that is not directly related to a visit, but still related to the procedure (e.g., phone calls from patient/family about a new symptom, communications with other providers).** There should be more clarity in the survey instructions as to how to understand and respond to these questions. **In addition, the survey should define "day" for the purposes of these and other questions.** It is not clear if "day" refers to the calendar day or a different 24-hour period surrounding the visit. The definition of "day" has different meanings between CMS and commercial insurance companies, so clarification is needed to accurately answer these survey questions. We also note that the question about work between visits only asks about the work of the physician or the physician's partner, not other qualified health professionals or clinical staff. It is unclear whether lack of inclusion of work of clinical staff was intentional or an oversight. Given that clinical staff often provide some of the services between visits, we recommend including clinical staff in this question as well.

CONFUSING TERMINOLOGY AND CONCERNS WITH SPECIFIC QUESTIONS

Confusing/incorrect terminology

HCPCS codes versus CPT codes: Throughout the survey, questions include references to "HCPCS codes" instead of "CPT codes." Although the survey notes that "*Level 1 HCPCS (Healthcare Common Procedural Coding System) codes are the same as CPT codes,*" HCPCS codes are not understood by surgeons and billers as procedure codes. It is possible that most physicians have never heard of HCPCS codes nor know what they represent. During office visits, in particular, if a surgeon has heard of HCPCS codes, they would think of them in the context of supplies such as casting materials, injectable drugs, etc. As such, "CPT codes" should be used throughout the survey instead of "HCPCS codes" because "CPT codes" are more recognizable to physicians.

Visit label: In an early question on the survey, there is a screen that requests the date of the visit and includes a box to add "Optional Visit Information," which will be the "visit label" in the survey. When asked for clarification, RAND indicated that this is a way for physicians to label the visit to differentiate the 10 visit surveys from each other. This was not clear from reading the survey alone, so more clarification should be provided about the meaning of the "visit label" and how that term will be displayed throughout the survey.

CPT code short descriptors: The survey asks the physician to indicate an E/M code that would have been reported for the facility/office visit if the visit were not part of the global period. The survey notes that the "definitions" of E/M codes have been shortened due to constraints. CPT uses the term "descriptors" not "definitions," so we ask that the RAND survey use the terms that are aligned with CPT. More importantly, the shortened descriptors are not correct and therefore add to the confusion of the survey.

For example, CPT code 99213 descriptor was shortened to:
Office/outpatient established patient, low complexity, low/moderate severity (15 min).

In contrast, the complete descriptor for CPT code 99213 states:
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

There are three key components to E/M code descriptors: history, exam, and medical decision making. FTF time can also be a factor if a majority of the FTF time is related to counseling and coordination of care. If RAND does not choose to include complete descriptors for this important question, then the shortened descriptions should be revised to accurately reflect the American Medical Association (AMA) CPT descriptions.

For example, CPT code 99213 could be shortened to:
Office visit, established patient, expanded problem focused history/exam, low complexity medical decision making, face-to-face is typically 15 minutes.

Irrelevant questions to be deleted

Several questions included in the survey are not relevant to assessing the work related to postoperative visits. Given that this survey is already long and time-consuming, we recommend deleting several questions. It is important that this survey be streamlined to focus on the goal of collecting relevant data on postoperative visits. That alone is a difficult task, and irrelevant questions make collecting accurate data more challenging.We recommend the following questions be deleted:

- ***"What is the primary payment source for the procedure(s)?"***
    - *Medicare or Medicare Advantage*
    - *Medicaid, CHIP, or other state-based program*
    - *Commercial*
    - *Other (including self-pay, TRICARE, VA, etc.)*
    - *Don't know*

This question does not relate to a physician's postoperative work and adds unnecessary time to the survey because the physician must find this information. Additionally, surgeons who are employed have little information on the insurance coverage of their patient. Also, in cases of emergent or urgent surgery, there is often not enough time for business office staff to gather, validate, and record the financial class of the patient. In such cases, it is not uncommon that the true insurance coverage of the patient is not determined for several weeks or months after the first encounter with the patient. Lastly, there is no evidence or suggestion from published studies that the insurance coverage of the patient has any bearing whatsoever on the level of postoperative visits.

- ***"Roughly, what percentage of your procedures is primarily paid for by each of the following sources?"***
    - *Medicare*
    - *Medicaid*
    - *Commercial insurance*
    - *Other (including self-pay, TRICARE, VA, etc.)*

This question does not relate to a physician's postoperative work and adds unnecessary time to the survey for the physician to find this information. Many surgeons would consider this question intrusive on the physician's private business matters. There is no evidence that this information has any bearing or impact on the level of postoperative visits for surgical patients.

- ***"What is the self-identified gender of the patient?"***
    - *Male*
    - *Female*
    - *Transgender*
    - *Does not identify as female, male, or transgender (non-binary/third gender)*

This question does not relate to a physician's postoperative work and is inappropriate for the purposes of collecting data to determine the level of postoperative visit. We do agree, however, that the question about the patient's age is appropriate to determine if the visit was related to a "typical" patient.

- ***"Where did this patient travel from to get to this office visit?"***
    - *Home*
    - *Another healthcare facility*
    - *Not known*
    - *Other*

This question does not relate to a physician's postoperative work, rather it incorrectly implies that providing transportation is a physician or clinical staff activity. This question adds unnecessary time to the survey for the physician to obtain this information and has nothing to do with code valuation.

- ***"Was the scheduling of this visit expected as part of the typical post-operative course for the procedure(s) performed?"***
    - *Expected*
    - *Unexpected*

This question is ambiguous and will not result in usable data. The level of postoperative care for any given patient is dependent upon many variables including co-morbidities. Whether a visit was planned or unplanned has no impact on level of care delivered. It is also unclear as to whether an "expected" scheduled visit refers to a visit that is expected for the patient, expected for the physician, or expected by the institution as part of their overall institutional quality improvement program.

- ***"Was a complication from the procedure(s) performed addressed at this office visit? (Please note that we are not collecting data on complications – this is only to understand how complications might affect the time and resources related to postoperative office visits.)"***
    - *Yes*
    - *No*

The word "complication" with or without the parenthetical note can be misunderstood. A complication can sometimes be a common postoperative occurrence (e.g., seroma, anomalous pain, constipation) or an atypical occurrence (e.g., wound infection). Any of these occurrences would result in additional work at a postoperative visit. This question is ambiguous and also redundant because the information that the survey is trying to obtain is requested in other questions.

- ***"Which, if any, of the following staff assisted you on the day of this visit? Please do not include nurse practitioners (NPs), physician assistants (PAs) and other staff who are billing for this visit separately from you. If no staff assisted you, please select "None" below."***
    - *Nurse Practitioner (NP)*
    - *Physician Assistant (PA)*
    - *Resident*
    - *Registered Nurse (RN)*
    - *Licensed Practical Nurse (LPN)*
    - *Medical/Technical Assistant (MTA)*
    - *Certified Surgical Technology (CST)*
    - *Other staff*
    - *None*

This question is redundant to all the subsequent questions that ask who provided face-to-face and non-face-to-face work.

- ***"For each of the following activities requiring supplies, please indicate who performed them on the day of this visit. These should be activities related to follow-up care for the procedure(s) that were the reason for this visit. If an activity was not performed, please select "Not performed" for that activity."***

We believe this question is meant to capture information about supplies that are typically used during postoperative visits. It is included in both the office visit and the facility visit surveys, yet this question would not apply to facility visits. Supplies in the facility are reimbursed through a facility fee. This question is only relevant to the office visit survey because in the office the supplies are the burden of the physician. Supplies in the facility setting, however, are not included in the RVU reimbursement for physicians. As such, this question should be deleted from the facility visit survey.

In addition, there are a number of specialty-related supplies that are not included on this list. We ask that RAND either add more supplies to this list or create an "other" box for respondents to add more information on supplies. Additional supplies could include: Doppler, ultrasound,

seroma aspiration materials, drains, injectable saline or heparin to flush a catheter, or wound VAC materials. For a more complete list of all postoperative visit supplies, we refer RAND to the CMS practice expense detail files published in conjunction with the physician fee schedule proposed and final rules.

- ***"Did you or another practitioner in your practice last see the patient yesterday (i.e. the day prior to this visit)?"***
    - *Yes*
    - *No*

We do not understand the intent of this question. If the visit occurred in the facility, the answer would most likely be "yes" and if the visit occurred in the office the answer would most likely be "no." Similar to our comments on other questions in this survey, this provides no new or usable information about the visit being surveyed. This question adds unnecessary time to the survey and should be deleted.

- ***"How much work was this visit compared to the typical post-operative visit that would occur at this point after this procedure"?***
    - *Much more work*
    - *Somewhat more work*
    - *About as much work*
    - *Somewhat less work*
    - *Much less work*

This question will not yield useful data unless you get a significant number of responses linked to the same postoperative visit for the same procedure or set of multiple procedures. This question requires the physician to consider, for example, the third postoperative office visit after a total colectomy for the survey patient compared to the third postoperative visit for all other total colectomy patients. The response to this question would only be useful if RAND received sufficient data points for the same CPT code, for the same numerical visit, and the same clinical scenario. The question about other reported procedures (i.e., multiple procedures) will provide a better sense of whether this was a typical postoperative visit, independent of whether it was the first, second, or third visit. Lastly, the thought process required to answer this question adds unnecessary time to the survey.

- ***"How much work was this visit for you personally, relative to a typical 99213 visit (office/outpatient established patient…..)? (Assume the work for a typical 99213 visit is 100%. A response of 50% indicates that this visit was half as much work as a typical 99213. A response of 200% indicates that this visit was twice as much work as a typical 99213.)"***
    - ___ %

This question follows another question where the survey respondent is asked to assign a CPT E/M code to the visit. If, for example, the respondent had stated in the prior question that the visit would be reported with 99213, we do not understand the purpose of asking the respondent to compare the survey visit to a typical 99213. This question adds confusion to the survey

because it could be interpreted that RAND is implying that there are easier 99213 visits and more difficult 99213 visits.

Confusing/incorrect answer choices

Several of the questions include answer choices that do not seem appropriate for the question or the context, or that do not seem to grasp the nuances of how surgeons practice. This has led to a great deal of confusion among our reviewers. Below are some examples:

- *"Where did this visit take place?"* (**office visit survey**)
    - *Office*
    - *Hospital outpatient department*
    - *Other ambulatory setting*

We recommend that instead of separating the survey into "office" and "facility" components, RAND should separate the survey into "office" and "all settings other than the office." This would leave "facility" as any place of service other than an office, for the purposes of the Global Surgical Services Survey. RAND should then provide detailed information about settings early in the survey at the point when a physician makes the selection that leads to the rest of the survey being determined to be an "office visit." We believe that most physicians will be able to discern the difference between office and everything else.

- *"Where did this visit take place?"* (**facility visit survey**)
    - *Acute inpatient, non-ICU*
    - *Acute inpatient, ICU*
    - *Post-acute, long-term care facility inpatient, or skilled nursing facility*
    - *Emergency department*
    - *Ambulatory surgical center*

These options are confusing because the reviewer is operating under the assumption that the visit for this survey was already determined to be an inpatient visit because it is describe as a "facility visit survey." Emergency department and ambulatory surgical center visits would be coded as outpatient (but not office), so this question was confusing to our reviewers who were approaching the facility survey as intended to capture data strictly on inpatient postoperative visits within a global period. The survey instructions should include clear definitions for what constitutes a "facility visit" for the purposes of this survey. This information should be included early in the survey at the point when a physician makes the selection that then led to the rest of the survey being determined to be a "facility visit" survey.

Confusing/difficult to answer questions

A number of questions were not easily understandable or otherwise confusing to our practicing physician reviewers. Some questions do not reflect a nuanced understanding of how surgeons practice and make the assumption that most surgeons have detailed knowledge of the duties encompassed by the entire staff of an office, or the activities of the clinical staff related to patient

care when a patient is in the hospital. Some of questions ask for information that is not available or easily accessible by the physician completing the survey. Below are some examples:

- **Activities and time for staff on the day of the visit**: Our reviewers have concerns about the question regarding activities performed on the day of the visit and the staff who performed the activity. The question indicates that for each of the activities performed on the day of the visit, the survey respondent should also list who performed the activity, how long the activity took, and all of the resources used by these clinical staff.

  This is a very difficult question for a physician to answer without consulting the medical record because the physician may not remember or be aware of all the activities that staff provided related to the visit or even be aware of all the clinical staff that provided activities, let alone the full list of resources. For example, clinical staff may have checked the patient in or out, taken vital signs, etc., without the physician knowing exactly who provided these services and/or what services were provided. In larger offices and clinics, the patient is checked in/registered in one location, then has a history, review of medications, vital signs, etc. in a second location, then is seen by the surgeon and other clinical staff in a third location within the clinic. Although this information would be documented in the medical record, it would not be information that the surgeon would be able to accurately report without referring to the record to finding all of the personnel that interfaced with a patient and then taking time to find out how long each activity took.

- **Staff time spent on visit**: A related question asks about the amount of time that the physician, NP/PA, resident, and other clinicians spent on the visit. Practices are busy with staff and patients moving around simultaneously. While services like these are documented, there has been no reason in the past to document the number of minutes dedicated to each service in this particular context and asking to retroactively report minutes associated with these services is an impossible ask certain to yield inaccurate data.

CONCLUSION

We stress that under the current Global Surgical Services Survey methodology it will be impossible to accurately determine postoperative work for specific procedures. For the reasons described above, we find this version of the survey fundamentally flawed as a means to collect useful information about the time, staff, and resources involved in furnishing postoperative visits and other services included in global surgical payment. We urge RAND to suspend use of the survey in its current form and to instead revise the survey to capture relevant information about postoperative visits using a format that is clear, straightforward, and logical. The survey should be directly related to capturing data on postoperative visits and should impose the least possible burden on the physicians in the survey sample.

Sincerely,

American College of Surgeons
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 Congress of Obstetricians and Gynecologists
American Society of Anesthesiologists
American Society for Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society for Metabolic and Bariatric Surgery
American Society of Plastic Surgeons
American Society for Surgery of the Hand
American Urogynecologic Society
American Urological Association
Congress of Neurological Surgeons
Society of Gynecologic Oncology
The Society for Thoracic Surgeons
Society for Vascular Surgery

Cc: Kathy Bryant
Ryan Howe