



## Commentary

# Since surgery isn't getting any easier, why is reimbursement going down? An update from the SGO taskforce on coding and reimbursement



Shitanshu Uppal<sup>a,b</sup>, Mark S. Shahin<sup>c</sup>, Jill A. Rathbun<sup>d</sup>, Barbara A Goff<sup>d,e,\*</sup>

<sup>a</sup> Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, University of Michigan, Ann Arbor, MI, United States

<sup>b</sup> Institute for Healthcare Policy and Innovation, University of Michigan, Ann Arbor, MI, United States

<sup>c</sup> Hanjani Institute for Gynecologic Oncology, Abington Hospital-Jefferson Health, Abington, PA, United States

<sup>d</sup> Galileo Consulting Group, Inc, Arlington, VA, United States

<sup>e</sup> Department of Obstetrics and Gynecology, University of Washington, Seattle, WA, United States

## ARTICLE INFO

## Article history:

Received 1 June 2016

Accepted 6 June 2016

Available online 11 December 2016

## ABSTRACT

In 2015, there was an 18% reduction in the Relative Value Units (RVUs) that the Center for Medicare and Medicaid Services (CMS) assigned to the Current Procedural Terminology (CPT) code 58571 (Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) → TLH + BSO). The other CPT codes for laparoscopic hysterectomy and laparoscopic supracervical hysterectomy (58541–58544 and 58570–58573) lost between 12 and 23% of their assigned RVUs. In 2016, the laparoscopic lymph node dissection codes 38570 (Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple), 38571 (Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy), and 38572 (Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), single or multiple) lost between 5.5 and 16.3% of their RVU's.

The goals of this article from the Society of Gynecologic Oncology (SGO) Task force on Coding and Reimbursement are 1) to inform the SGO members on why CMS identified these codes as a part of their misvalued services screening program and then finalized a reduction in their payment levels; and 2) outline the role individual providers have in CMS' methodology used to determine the reimbursement of a surgical procedure.

© 2016 Elsevier Inc. All rights reserved.

## 1. What are relative value units (RVUs) and how are they calculated?

Since January 1, 1992, Medicare has paid for physician services based on a system that relies on national relative values that are established for work, practice expense (PE) and malpractice (MP), which are then adjusted for geographic cost variations. These values are multiplied by a conversion factor (CF) to convert the RVUs into a payment rate. The physician work RVU component of a service means the portion of the resources used in furnishing the service that reflects the physician's time and intensity. CMS establishes work RVUs for new, revised, and potentially misvalued codes based on a review of information that generally includes, but is not limited to, recommendations received from the American Medical Association/Specialty Society Relative Value Update Committee (RUC), other advisory bodies, public commenters, medical literature and comparative databases, as well as a comparison of the work for other codes within the Medicare Physician Fee Schedule, and

consultation with other physicians and health care professionals within CMS and the federal government [1].

When a new or revised CPT code is approved by the CPT Editorial Panel or CMS and the RUC identify potentially misvalued codes then specialty societies can survey their members to obtain data on the amount of work involved in a service and develop recommendations based on the survey responses. Specialty Society Advisors present these recommendations at the RUC meeting. Advisors presentations are followed by a thorough question and answer period during which the Advisors must defend every aspect of their proposal. The RUC may decide to adopt a specialty society's recommendation, refer it back to the specialty society or modify it before submitting it to CMS. RUC's recommendations are forwarded to CMS for their review and CMS makes the final determination of the RVUs assigned to a procedural code [2].

One of the categories that CMS uses to identify potentially misvalued codes for review at the RUC is codes for which there has been a site of service shift resulting in what CMS terms a "site of service anomalies," which means the service is now typically – i.e. greater than 50% of the cases – performed in the hospital outpatient department, but the code still is valued for an inpatient stay in the hospital [3]. This

\* Corresponding author at: Department of Obstetrics and Gynecology, Seattle, WA USA 98195, United States.

E-mail address: [bgoff@uw.edu](mailto:bgoff@uw.edu) (B.A. Goff).

is the category/screen that identified the laparoscopic hysterectomy codes as being potentially misvalued and triggered the review and survey process as outlined above to occur. Laparoscopic lymphadenectomy codes were also identified as potentially misvalued and also went through review. Due to the change in the typical site of service and the results of these reviews and surveys, CMS established a significant reduction in RVUs for these procedures.

## 2. Why do RVUs matter?

Medicare, Medicaid and most private insurance payers calculate reimbursement for surgical procedures with a simple formula:

$$\text{PAYMENT} = \text{CF}(\text{conversion factor}) \times \text{Total RVUs} \\ \times \text{GPCI (Geographic Pricing Cost Index)}$$

The payer determines the conversion factor and CMS determines the RVUs. Most private payers also use this RVUs to set their own payments.

The physician surveys play an important role in determining the RVUs assigned to a CPT codes. Specialty societies conduct surveys of their members, review the results and prepare their recommendations to the RUC. These surveys ask about time and intensity to perform a specific procedure. Physician work is determined by 1) the time required to perform a procedure; 2) the intensity, which could be thought of as the physical and mental effort and 3) the stress due to potential risk of injury to the patient during the procedure.

As an example, the CY 2014 Medicare conversion factor was \$35.82. In 2014, the total RVUs for TLH + BSO (CPT code 58571) was 30.20 and therefore surgeons were paid on average \$1081.16. In 2015, the total RVUs were reduced to 26.28 and with the CY 2015 conversion factor of \$35.80, total payment was decreased to \$940.86 (–15%). This is by far the most common procedure performed by the majority of gynecologic oncologists. In addition to reduction in reimbursement for this procedure, physicians who are benchmarked based on either work or total RVUs are also significantly impacted.

## 3. Why did the surveys filled out by gynecologic oncologists and general obstetrician/gynecologist (Ob/Gyn) result in such dramatic reductions in RVUs?

Of all of the factors that specialty societies consider in making their recommendations to the RUC, the most important factor is the time to perform the procedure and number of times a surgeon sees a patient in the postoperative period, both in the hospital and office visits. Prior to the 2015 review of these codes, the CMS Physician Work Time Files reported the intra-service – i.e. skin-to-skin – time to perform a TLH + BSO (CPT code 58571) as 135 min. Because this code previously was a typical inpatient procedure versus an outpatient procedure, the CMS Physician Work Time File contained data that patients were seen for 3 hospital visits (level 1, level 2, and a discharge management). In

addition, there were 2 outpatient visits (level 2 and level 3) in the 90-day global period (Table 1). However, after the codes were reviewed by CMS, in the 2015 CMS Physician Work Time File, the intra operative time for TLH + BSO was 90 min (45 min lower than previous estimates). And, because the code was now no longer typical as an inpatient, all hospital visits except the discharge visit were removed by CMS and the minutes for these visits deducted from the total time. There were two office visits (both level 3) in the 90-day global period. This significant reduction in the minutes for these procedures resulted in the lower RVUs (Table 1).

## 4. How good are surgeons at estimating surgical time?

The SGO Taskforce on Coding and Reimbursement conducted surveys to evaluate this question. First, we asked members of the taskforce to obtain actual skin to skin time and room in/room out time from electronic operating room logs for TLH + BSO done as a stand-alone procedure by either general Ob/Gyn or gynecologic oncologist. A total of 657 sequential cases were collected from 7 different practices. The average skin to skin time was 139 min and average room in/room out time was 180 min suggesting the pre-2015 times were more accurate than what was recommended by CMS.

Next, we expanded our research to include all hysterectomies in the National Surgical Quality Improvement Program (NSQIP) database (participant user files 2011, 2012 and 2013). Details of the sampling strategy, data abstraction procedures and outcomes in the NSQIP have been documented extensively [4,5]. The operative time in the NSQIP database was analyzed for TLH + BSO. In order to get accurate operative time for this procedure, cases with concurrent procedures were not included in the analysis. Mean, median, 25th percentile and 75th percentile times for procedures routinely performed by the gynecologic oncologists were calculated. A total of 8011 cases of TLH + BSO only were identified. The median time was 121 min for all cases and 130 min for cases with final diagnosis of malignancy. (Table 2)

Finally, we surveyed the members of the Society of Gynecologic Oncology (SGO) about the number of inpatient and outpatient visits they perform in the 90-day global period. The survey was sent to 1068 practicing gynecologic oncologists and 117 (11%) returned the survey. The majority of respondents indicated that they provided a level 2 inpatient visit; a discharge management visit and 2 or more office visits post discharge (Table 1). These survey results highlight that gynecologic oncologists routinely render more services compared to the numbers in the CMS Physician Work Time Files.

## 5. Why is this important for gynecologic oncologists to understand the time it takes to care for their patients?

As data was collected for TLH + BSO, additional procedures may be identified over the next several years by CMS as also being potentially misvalued that are relevant to most gynecologic oncologists. In general,

**Table 1**  
Work Estimates for TLH + BSO (CPT -58571).

	Operative time (minutes)	Subsequent hospital visit level 2 (CPT-99232)	Discharge day management less than 30 min (CPT-99238)	Subsequent outpatient visit level 2 (CPT-99212)	Subsequent outpatient visit level 3 (CPT-99213)	Subsequent outpatient visit level 4 (CPT-99214)
2014 CMS physician work time files	135	2	1	1	1	0
2015 CMS physician work time files	90	0	0.5	0	2	0
Data collected from SGO member OR logs	139	1	1	0	1	1
NSQIP time	130.4	NA	NA	NA	NA	NA

NA – Not Available.

NSQIP – National Surgical Quality Improvement Program.

TLH + BSO – Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s).

**Table 2**

National Surgical Quality Improvement Program (NSQIP) estimated operative times for most common surgical procedures performed by gynecologic oncologists.

Procedure	CPT code(s)	N	ALL cases				Final diagnosis malignancy					wRVU
			Mean time (Min)	Median time (Min)	25th percentile	75th percentile	N	Mean time (Min)	Median time (Min)	25th percentile	75th percentile	
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	58150	9661	113	102	76	138	744	125	112	81	155	17.31
Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	58571	8011	130	121	93	159	1301	142	133	106	170	15.00
Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	58571 + 38571	NA	NA	NA	NA	NA	419	173	167	126	209	15 + 14.76*
+ Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy												
Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or more; with removal of tube(s) and/or ovary(s)	58573	1529	174	154	120	199	116	175	165	129	207	20.79

\* The second procedure is only given 50% of the RVUs.

procedures have undergone reductions in RVUs, and therefore payment, because survey responders have typically reported lower intraoperative times and fewer post-operative visits associated with work of procedure than what had previously been reported.

CMS has also now finalized its data collection methodology for time spent and visits conducted by surgeons during the global surgical period as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). SGO members practicing in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island may be required starting July 1, 2017 to report all post-operative visits and activities to patients using CPT code 99024. CMS will be collecting this data on surgical procedures that are performed by more than 100 practitioners and are either furnished more than 10,000 times or have allowed charges of more than \$10 million annually. While CMS is not finalizing the penalty of 5% for those that do not report, the separate reporting of these post-operative activities for SGO members practicing in these states in groups of 10 or more will be mandatory. As the list of surgical procedures is finalized and the instructions for reporting released, SGO Coding Taskforce will be notifying our members in these states. CMS has said that it will use the data collected through this exercise to review payments for surgical procedures in the future.

National data would suggest that most gynecologic oncologists are caring for patients who typically have more co-morbid conditions including obesity and that their surgical procedures are more complicated as a result. When data is collected, gynecologic oncologists need to take these factors into account for their typical patient. Based on the data presented above including SGO member survey and NSQIP database, it is quite apparent that the times post 2015 in the CMS Physician Work Time Files for these procedures are underestimating the work effort and time.

In the coming year, additional data collection efforts for gynecologic oncology procedures will be forthcoming, such as the data for time and visits spent during the global surgical period as mandated by MACRA

with collection starting on July 1, 2017. It is important for gynecologic oncologist to carefully respond to these important data collection efforts and to attend SGO Coding and Reimbursement Workshops to learn more about how data is used by the Medicare program to calculate RVUs and set physician payments. It is critical that physicians investigate the time they spend taking care of patients. Based on our research, it is clear that the surgeon estimates without concrete data can be subject to recall bias resulting in severely underestimated reporting of their efforts. We would encourage members to review data from their own institution regarding actual times to perform procedures and actual length of stay. Responses to CMS or RUC surveys should be taken seriously with an understanding of typical patterns of practice to make sure accurate information is reported. In these instances, casual reporting of inaccurate information can cause all practicing gynecologic oncologists significant financial harm in the long term. It is important to understand the significance of these surveys and data collection efforts with respect to reimbursement.

## References

- [1] CY, Final Medicare Physician Fee Schedule Rule, Federal Register/Col 80, no 220/Monday, November 16, 2015, 2016 70889.
- [2] American Medical Association, Medicare RBRVS: the physicians guide, Am. Med. Assoc. (2016).
- [3] CY, Final Medicare Physician Fee Schedule Rule, Federal Register/Vol 75, no 228/Monday, November 29, 2010, 2011 73216.
- [4] S.F. Khuri, J. Daley, W. Henderson, K. Hur, J. Demakis, J.B. Aust, et al., The Department of Veterans Affairs' NSQIP: the first national, validated, outcome-based, risk-adjusted, and peer-controlled program for the measurement and enhancement of the quality of surgical care. National VA surgical quality improvement program, *Ann. Surg.* 228 (1998) 491–507.
- [5] S.F. Khuri, W.G. Henderson, J. Daley, O. Jonasson, R.S. Jones, D.A. Campbell Jr., et al., Successful implementation of the Department of Veterans Affairs' National Surgical Quality Improvement Program in the private sector: the patient safety in surgery study, *Ann. Surg.* 248 (2008) 329–336.