Legislative Request Regarding Transition of 10- and 90-day Global Codes

Request

Congress should rescind the policy in the 2015 Final Medicare Physician Fee Schedule Rule to transition 10– and 90–day global period codes to 0-day global period codes in 2017, and 2018, respectively.

Background

The Centers for Medicare & Medicaid Services (CMS) recently finalized a policy that *will transition all 10- and 90-day global codes to 0-day global codes by 2017 and 2018 respectively*. Global codes include necessary services normally furnished by a surgeon before, during, and after a surgical procedure. Global codes are classified as 0-day (typically endoscopies or some minor procedures), 10-day (typically other minor procedures with a 10-day post-operative period), or 90-day (typically major procedures with a 90-day post-operative period). Approximately 4,200 of the over 9,900 Current Procedural Terminology (CPT) codes are 10- or 90-day global codes.

Despite the fact that the policy will affect 10-day global codes in 2017 and 90-day global codes in 2018, CMS has not yet developed a methodology for making this transition. Indeed, the agency has stated that it does not know how best to proceed. However, in order to implement the change, CMS must begin to transition all these codes no later than February 2016.

Rationale

The policy to transition 10- and 90-day global codes to 0-day has a number of potential consequences that should be well understood before implementation:

Reduces patient access and quality of care

- Under global payment, patients typically pay one copay for the global bundled procedure and related follow-up care. If 10- and 90-day global codes are transitioned to 0-day global codes, patients will have a copay for the procedure and additional separate co-pays for other services, including each of the follow-up visits. Patients may also be responsible for separate payment of supplies and drugs necessary at post-op visits that are currently bundled into the global payment, but are not bundled into visit codes. This could considerably increase the financial burden on patients, or worse, discourage them from coming back for follow-up care. This would disproportionally affect the sickest patients who require more follow-up care than is currently bundled into global payment.
- In the hospital critical care setting, the global payment structure allows the surgeon to oversee and coordinate care related to the patient's recovery. Without global bundled care, care will be fragmented and certain conditions most likely to be detected by a surgeon may go undiagnosed.

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Undermines the current SGR legislation and other Medicare reform initiatives

- CMS initiatives for payment are all moving towards larger bundled payments. Deconstruction of the current payment structure for physicians is counterintuitive to the end goal of providing more comprehensive and coordinated care for the patient.
- Current bipartisan, bicameral legislation, to repeal and replace the flawed sustainable growth rate formula calls for a "period of stability" in physician pay to allow physicians to transition to alternative payment models. This proposal intends to introduce new complexities into an already flawed system and stymie that progress.

Increases administrative burden

- The administrative burden on surgical practices and CMS (and its contractors) will be significant. The American Medical Association estimates that eliminating the global package will result in 63 million additional claims per year to account for post-surgical evaluation and management services. Clearly, this will add unnecessary costs to the claims processing system.
- Many global surgical codes have already been revised, or are in the process of revision. It is not necessary to engage in this time-consuming, disruptive and duplicative exercise.

Obstructs clinical registry data collection and quality improvement

- If patients forgo follow-up treatment or seek it from other providers, this policy would have a deleterious effect on surgeons' ability to collect information on patient outcomes in clinical registries, undermining many of the most meaningful quality improvement initiatives.

Because this policy will have a wide-ranging impact on patients, physicians, hospitals, third-party payers, and CMS, we recommend that Congress take the necessary steps to prevent CMS from implementing this policy.