

ENSURING APPROPRIATE GLOBAL CODE VALUES IN MEDICARE

Request

Congress should direct the Centers for Medicare & Medicaid Services (CMS) to adjust the evaluation and management (E/M) post-operative visits included in 10-day and 90-day global surgical codes to reflect the updated office/outpatient E/M code payment increases that were implemented on January 1, 2021.

Background

Medicare currently pays surgeons and other specialists a single fee (global payment) when they perform major or minor surgery such as back surgery, joint replacement, heart surgery, cataract surgery, or provide maternity care. This single fee covers the costs of the surgery plus related care prior to surgery and follow-up care within a 10- or 90-day post-operative timeframe. CMS establishes these global payments to include payment for both the surgical procedure and the post-operative/follow-up visits—a type of E&M visit. Post-operative visits include services such as post-surgical pain management; local incision care; removal of sutures and staples, drains and casts; and more.

In its final 2021 Medicare Physician Fee Schedule (PFS), CMS reaffirmed its decision not to apply the new 2021 increased payment adjustment to the E/M portion of the global surgical codes. The agency did, however, modify its decision and allowed these increases only for certain services such as maternity care global services and emergency department visits. Arbitrarily adjusting some E/M visits but not others conflicts with current law, which prohibits CMS from paying physicians differently for the same work. In addition, every time CMS has increased the payments for new and established office visits in the past, the agency has also adjusted the global surgery bundled payments to account for the increased values for the E/M portion of these codes.

Impact on Ophthalmology

Ophthalmology services are an excellent example of why CMS' current policy is flawed. As a result of the policy, ophthalmologists are being paid less in 2021 for post-operative visits than they should be under the existing statute requiring equal pay for equal work.

Retinal Detachment Surgery: Many ophthalmic surgery codes have several post-operative visits included in the global payment. For example, when surgeons treat retinal tears on an emergent basis to prevent progression to retinal detachments that can cause permanent visual loss, payment is for the surgery itself and two post-operative visits included within the 10-day global period for the procedure. These global surgical codes are in the process of being revalued. CMS' decision to value post-operative visits less than their equivalent office visits will result in surgeons receiving LESS pay for the physician work* of the procedure AND the two post-operative visits than if the surgeon did the procedure for free and instead of submitting a claim for the surgery, billed only the two post-operative visits at the current rate for E/M office visits. This makes no sense and emphasizes why the policy must change. *Physician work is the main component of payment for surgical procedures. The other components are practice expense and malpractice insurance costs.

Cataract Surgery: One reason CMS uses to justify its decision is that the agency is not convinced that surgeons provide all the post-operative visits included in the global surgical payment. However, there is a process in place through the American Medical Association's Relative Value Scale Update Committee (RUC), a medicine-supported group that advises the agency on Medicare payments for physician services, to evaluate any global codes that CMS believes may be "misvalued." The recent reevaluation of cataract surgery fees is an example of how the process works to ensure codes are appropriately valued.

Through the AMA RUC process, CMS accepted the RUC recommendation and revalued cataract surgery payment in 2019. They agreed that ophthalmologists are providing three post-operative visits in the 90-day global period. Since CMS accepted the revaluation of the cataract surgery payment with three post-operative visits (one level 2 visit and two level 3 visits), there is no reason that these doctors should not be paid at the same level E/M visit payments as other physicians when they are providing the same level of service per patient.

Strabismus Surgery: With many states basing their Medicaid reimbursement on Medicare values, 2022 payment reductions for strabismus surgery could affect access for vulnerable children, further exacerbating existing disparities in the diagnosis and treatment of pediatric strabismus. Untreated strabismus can lead to permanent loss of vision in one eye and loss of depth perception, limiting vocational opportunities for those affected. As a result of revaluation, strabismus surgery codes will see significant Medicare payment cuts, possibly ranging from 2% to 61%, going into effect in 2022. If CMS improves the Medicare payment of these global codes through equity adjustments to the built-in E&M post-operative visits, it will help mitigate payment reductions for Medicaid services that disproportionately affect vulnerable populations or the providers who serve them.

Recommendation

It is critical that CMS increase the E/M portion of the global codes in the upcoming proposed 2022 Medicare Physician Fee Schedule because to do otherwise will:

- ***Disrupt the relativity in the fee schedule.*** Changing the values for some E/M services, but not for others, disrupts the relativity mandated by Congress as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239), which was implemented in 1992 and refined over the past 27 years. In the past, every time the payments for new and established office visits were increased, CMS also adjusted the global surgery bundled payments to account for the increased values for the E/M portion of these codes.
- ***Create specialty differentials.*** The Medicare statute specifically prohibits CMS from paying physicians differently for the same work, and the “Secretary may not vary the . . . number of relative value units for a physician’s service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.” Failing to adjust the global code payment is equivalent to paying some physicians less for providing the same E/M services.
- ***Conflict with section 523(a) of MACRA.*** Through the Medicare Access and CHIP Reauthorization Act (MACRA), Congress required CMS to collect data on global codes. Notwithstanding this ongoing project, nothing in Section 523(a) of MACRA precludes CMS from making these equity adjustments to the global codes in the meantime.
- ***Process exists to re-evaluate “misvalued” codes.*** If CMS feels that specific global codes are “misvalued,” the agency should request the AMA’s RUC to review these codes to ensure the global payments accurately reflect the actual services being provided to patients.

Congress should direct the CMS to adjust the values of the E/M post-operative visits included in 10-day and 90-day global surgical codes to reflect the updated office/outpatient E/M code payment increases that were implemented on January 1, 2021.