



GLOBAL SURGICAL CODES

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. In fact, 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 payments, 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 copays 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 disproportionately affect the sickest patients who require the most 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 the global bundled care, care will be fragmented and certain conditions most likely to be detected by a surgeon may go undiagnosed.
- ❖ 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.

For More Information Contact: Katie O. Orrico, Director
AANS/CNS Washington Office
725 15th Street, N.W., Suite 500
Washington, DC 20005
Office: 202-446-2024
Email: korrico@neurosurgery.org

*The **American Association of Neurological Surgeons** was founded in 1931 and is dedicated to advancing the specialty of neurological surgery in order to promote the highest quality of patient care. The **Congress of Neurological Surgeons** was founded in 1951 and exists to enhance health and improve lives worldwide through the advancement of education and scientific exchange. The AANS and CNS are the two largest scientific and educational associations for neurosurgical professionals in the world and represent over 4,000 practicing neurosurgeons in the United States. Neurological surgery is the medical specialty concerned with the prevention, diagnosis, treatment and rehabilitation of disorders that affect the entire nervous system, including the spinal column, spinal cord, brain and peripheral nerves. For more information, please visit www.aans.org or www.cns.org, read our blog www.neurosurgeryblog.org, follow us on [Twitter](#) or connect with us on [Facebook](#).*

GLOBAL SURGICAL CODES

Suggested Legislative Language

1 **SEC. __. ENSURING BENEFICIARY ACCESS TO QUALITY SURGICAL CARE**

2 (a) NULLIFICATION OF GLOBAL SURGERY PERIOD MODIFICATION RULE.—The global surgery period
3 modification (as defined in subsection (d)(1)) shall have no force or effect in law or regulation.

4 (b) PROHIBITION ON IMPLEMENTATION OF RULE IN LATER RULEMAKING.—The Secretary of Health and
5 Human Services—

6 (1) shall continue the use of 10-day and 90-day global surgery service periods under the Medicare
7 program for surgical services furnished on or after the date that is January 1, 2015, including for HCPCS
8 codes for surgical services issued on or after such date; and

9 (2) may not implement the global surgery period modification, or any substantially similar rule,
10 through any rulemaking, subregulatory guidance or otherwise that is promulgated or issued on or after
11 the date of the enactment of this Act.

12 (c) BUDGET NEUTRAL IMPLEMENTATION.—The Secretary of Health and Human Services shall carry out
13 this section in a budget neutral manner.

14 (d) DEFINITIONS.—In this section:

15 (1) GLOBAL SURGERY PERIOD MODIFICATION.—The term “global surgery period modification” means
16 the provisions of the 2015 Medicare Physician Fee Schedule final rule (as defined in paragraph (2))
17 relating to a finalized proposal to transition and revalue all 10- and 90-day global surgery services billed
18 under the Medicare program with 0-day global periods, beginning with the 10-day global services in
19 calendar year 2017 and following with the 90-day global services in calendar year 2018, contained on
20 pages 67582 through 67591 of Volume 79 of the Federal Register.

21 (2) 2015 MPFS FINAL RULE.—The term “2015 Medicare Physician Fee Schedule final rule” means
22 the final rule published on November 13, 2014, by the Department of Health and Human Services,
23 Centers for Medicare & Medicaid Services entitled “Medicare Program; Revisions to Payment Policies
24 Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the
25 Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Final
26 Rule” (79 FR 67548 through 68010).

27 (3) MEDICARE PROGRAM.—The term “Medicare program” means the program of health insurance for
28 the aged and disabled established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

29 (e) EFFECTIVE DATE.—This section shall apply to items and services furnished on or after January 1,
30 2015, to individuals entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act
31 (42 U.S.C. 1395c et seq.), or enrolled under Part B of such title (42 U.S.C. 1395j et seq.), or both.