CMS' Planned Changes in Payment Policies Will Lead to Drastic Cuts for Surgeons

Recently finalized policies from the Centers for Medicare and Medicaid Services (CMS) will have drastic consequences for Medicare patients seeking surgical services. These policies also conflict with current law and are unjustified. Without congressional intervention, these policies will result in significant cuts to physician payment for most surgical services delivered to Medicare patients, exacerbate surgical workforce shortages and the crisis of rural hospital closures.

The surgical associations listed below ask Congress to:

1.) Require CMS to apply the finalized 2021 office and outpatient evaluation and management (E/M) adjustments to the surgical codes with global periods in order to comply with the prohibition on specialty differentials established by Congress in the Omnibus Budget Reconciliation Act (OBRA) of 1989(P.L. 101-239) for the same service; and

2.) Halt CMS' finalized policy to redistribute payments to certain specialties at the expense of others via an add-on code that was created with little data, rationale, or resource input.

E/M Global Code Policy Changes

In the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (PFS) final rule published in November 2019, CMS increased the payment levels for stand-alone office and outpatient E/M codes. However, CMS did not apply the payment adjustment to the corresponding E/M portion of the global codes. Arbitrarily adjusting some E/Ms but not others conflicts with OBRA, which prohibits Medicare from making Medicare payments to physicians for the same work but at different levels because of the physician's specialty. *For more detailed background, see attachment A.*

Add-on Code Policy Changes

In 2018, CMS proposed to restructure the coding system for office and outpatient E/M visits to reduce documentation burden. Because certain specialties would experience payment cuts, due to the proposed collapse of the payment levels, CMS proposed add-on codes to provide an additional payment specifically for primary care and certain specialty visits to minimize payment cuts associated with these code changes. However, CMS did not move forward with the single payment proposal and will instead retain the multiple levels of E/M codes. Therefore, CMS' current justification for again including an add-on code (GPC1X) in the new E/M approach, no longer exists. Now instead of correcting a system that would have resulted in unfair payment reductions, the agency is creating a new coding scheme that inappropriately discriminates among physician specialties. *For more detailed background, see attachment B.*

Compounding Effect of E/M Global Code Policy and Add-on Code

The combined policies proposed by CMS to not apply a proportionate increase to the E/M component of global codes and moving forward with the unjustified add-on code will have a devastating effect on a significant portion of specialty care due to the statutory requirements for budget neutrality under the Medicare Physician Fee Schedule. *For more detailed information, see attachment C.*

American College of Surgeons
American Academy of Ophthalmology
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American Society of Bariatric Surgeons
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgeons
American Society of Colon and Rectal Surgeons
American Society of Hand Surgeons
American Society of Plastic Surgeons
American Urogynecologic Society
American Urological Association
Congress of Neurological Surgeons
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Gynecologic Oncology
Society of Thoracic Surgeons
Society for Vascular Surgery

CMS E/M Proposal Goes Against Precedent and Violates Current Law
(Attachment A)

Background on Global Code Values

Medicare currently pays surgeons and other specialists a single fee (global payment) when they perform major or minor procedures such as back surgery, brain tumor removal, joint replacement, heart surgery, cataract surgery, colon resection, or provide maternity care. This single fee, which is established by CMS, covers the costs of the procedure plus related care before the procedure and follow-up care within a 10- or 90-day timeframe. For maternity care, this single fee covers nine months of prenatal care visits, labor and delivery and postpartum care. The services provided during pre-and post-operative/follow-up visits included in the global period are the same as the types of services that could be provided as stand-alone evaluation and management (E/M) visits.

In the CY 2020 Medicare Physician Fee Schedule (PFS) final rule published in November 2019, CMS increased the payment levels for stand-alone office and outpatient E/M codes. However, CMS did not apply the payment adjustment to the identical E/M portion of the global codes. Each time stand-alone office visits increased since 1997, CMS also increased the visits bundled into the surgical global period. These increases occurred in 1997, 2007, and 2011. Arbitrarily adjusting some E/Ms but not others, as finalized in 2019, conflicts with current law.

Rationale

If CMS applies the E/M adjustments to stand-alone office visit E/M codes, then such adjustments should also be made to the E/M component of the global codes, consistent with law as well as previous actions by the agency. It is imperative that CMS take this crucial step because the current policy:

- ***Creates specialty differentials***. As part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239), which created the resource-based relative value scale (RBRVS) used to determine physician payment amounts, Congress specifically prohibits CMS from paying physicians differently for the same work in Medicare. This prohibition states that the "Secretary may not vary the . . . number of relative value units for a physicians' 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 codes does *exactly* this; - paying some physicians less for providing the same E/M services.
- ***Relies on a faulty interpretation of section 523(a) of MACRA***. Through the Medicare Access and CHIP Reauthorization Act (MACRA), Congress required CMS to collect data on global codes. CMS' rationale for not adjusting the global codes relies on this ongoing data collection. Notwithstanding this ongoing project, nothing in Section 523(a) of MACRA precludes CMS from adjusting the global codes. In fact, the rule of construction specifically authorizes CMS to do so.

CMS Proposal to Create Add-on Code Is No Longer Justified
(Attachment B)

Background on CMS Add-on Code

The code sets to bill for E/M services are organized into five levels. In general, the more complex the visit, the higher the level of code a physician or provider may bill. To reduce the documentation burden associated with E/M visits, CMS initially proposed collapsing E/M level 2-5 visits into a single code/payment rate. Because this new code would pay physicians at approximately a level 3 payment rate, specialties that typically bill levels 4 and 5 E/Ms would experience payment cuts, so CMS proposed new add-on codes to provide an additional payment specifically for primary care and certain specialty visits.

However, CMS did not move forward with the single payment proposal and will instead retain the multiple levels of office and outpatient E/M codes. According to CMS, despite finalizing increased payment for office and outpatient E/M codes (some levels with payment increases above 40%), CMS desires to pay even more for certain types of services without expressing what additional resources those services or visits require. In the proposed rule estimates, the agency expects the newly proposed add-on code, GPC1X, to be used to provide additional payment for 100 percent of claims provided by certain specialties. However, CMS' original justification for the creation of this add-on code no longer exists and is now unnecessary.

Rationale

- ***Creates distortion rather than correcting it.*** The add-on code was initially proposed last year to compensate specialties who billed predominately level 4 or 5 E/Ms. These physicians would have been disadvantaged by the lower payment rate resulting from the prior CMS proposal to create a single payment rate for E/M levels 2-5. This year, CMS opted instead to keep the 5 levels of codes. Therefore, instead of correcting payment distortions caused by the CMS E/M policy proposal, the implementation of this code would create its own distortion, benefiting some while disadvantaging others without justification.
- ***No longer needed.*** If more time or work is required for visits provided by these specialties, they may simply bill a higher-level E/M code to account for the extra time or work. CMS has not explained what additional resources these specialties use for which payment is not covered under the existing revised E/M codes, thereby necessitating the additional payment from the add-on code.

Impact Chart
(Attachment C)

	Current CMS Policy	**Apply E/M Adjustment to Global Code & Eliminate Add-on Code**
Specialty	Projected 2021 Medicare Payment	Projected 2021 Medicare Payment
Cardiac Surgery	-7.01%	-3.49%
Thoracic Surgery	-6.76%	-3.10%
Ophthalmology	-6.57%	1.26%
Vascular Surgery	-6.43%	-3.27%
Neurosurgery	-6.05%	-1.76%
Plastic and Reconstructive Surgery	-6.04%	1.05%
General Surgery	-5.67%	-1.14%
Colon Rectal Surgery	-5.43%	-1.17%
Surgical Oncology	-4.63%	0.79%
Maxillofacial Surgery	-4.43%	1.92%
Orthopaedic Surgery	-3.88%	1.11%
Hand Surgery	-3.80%	3.11%
Anesthesiology	-2.91%	-0.22%
Gynecologic Oncology	-2.06%	2.56%

Note: While obstetrician-gynecologists will be negatively impacted by this policy, Obstetrics and Gynecology is not listed in this table because the Medicare impact estimates do not accurately represent obstetrician-gynecologists' patient population or case mix.