current coding structure may be confusing, especially since the number of specimens associated with prostate biopsies is relatively homogenous. For example, G0416 (10–20 specimens) represents the overwhelming majority of all Medicare claims submitted for the four G-codes. Therefore, in the interest of both establishing straightforward coding and maintaining accurate payment, we believe it would be appropriate to use only one code to report prostate biopsy pathology services. Therefore, we propose to revise the descriptor for G0416 to define the service regardless of the number of specimens, and to delete codes G0417, G0418, and G0419. We propose to revise G0416 for use to report all prostate biopsy pathology services, regardless of the number of specimens, because we believe this will eliminate the possible confusion caused by the coding while maintaining payment accuracy.

Based on our review of medical literature and examination of Medicare claims data, we believe that the typical number of specimens evaluated for prostate biopsies is between 10 and 12. Since G0416 is the code that currently is valued and used for between 10 and 12 specimens, we are proposing to use the existing values for G0416 for CY 2015.

In addition, we are proposing G0416 as a potentially misvalued code for CY 2015. We seek public comment on the appropriate work RVUs, work time, and direct PE inputs.

(7) Obesity Behavioral Group Counseling—GXXX2 and GXXX3

Under section 1861(ddd) of the Act, we added coverage for a new preventive benefit, Intensive Behavioral Therapy for Obesity, effective November 29, 2011, and created HCPCS code G0447 (Face-to-face behavioral counseling for obesity, 15 minutes) for reporting and payment of individual behavioral counseling for obesity. Coverage requirements specific to this service are delineated in the Medicare National Coverage Determinations Manual, Pub. 100–03, Chapter 1, Section 210, available at *http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf.*

It has been brought to our attention that behavioral counseling for obesity is sometimes furnished in group sessions, and questions were raised about whether group sessions could be billed using HCPCS code G0447. To improve payment accuracy, we are creating two new HCPCS codes for the reporting and payment of group behavioral counseling for obesity. Specifically, we are creating GXXX2 (Face-to-face behavioral counseling for obesity, group (2–4), 30 minutes) and GXXX3 (Face-to-face behavioral counseling for obesity, group (5–10), 30 minutes). The coverage requirements for these services would remain in place, as described in the National Coverage Determination for Intensive Behavioral Therapy for Obesity cited in this section of the proposed rule. The practitioner furnishing these services would report the relevant group code for each beneficiary participating in a group therapy session.

We believe that the face-to-face behavioral counseling for obesity services described by GXXX2 and GXXX3 would require similar per minute work and intensity as HCPCS code G0447, which is a 15-minute code with a work RVU of 0.45. Therefore, to develop proposed work RVUs for HCPCS codes GXXX2 and GXXX3 we scaled the work RVU of HCPCS code G0447 to reflect the differences in the codes in terms of the time period covered by the code and the typical number of beneficiaries per session. Adjusting the work RVU for the longer time of the group codes results in a work RVU of 0.90 for a 30-minute session. Since the services described by GXXX2 and GXXX3 will be billed per beneficiary receiving the service, the work RVUs and work time that we are proposing for these codes are based upon the typical number of beneficiaries per session, 4 and 9, respectively. Accordingly, we are proposing a work RVU of 0.23 with a work time of 8 minutes for GXXX2 and a work RVU of 0.10 with a work time of 3 minutes for GXXX3.

Using the same logic, we are proposing to use the direct PE inputs for GXXX2 and GXXX3 currently included for G0447, prorated to account for the differences in time and number of beneficiaries described by the new codes. The proposed direct PE inputs for these codes are included in the CY 2015 proposed direct PE input database, available on the CMS Web site under the downloads for the CY 2015 PFS proposed rule at *http://www.cms.gov/PhysicianFeeSched/.* We are also proposing to crosswalk the malpractice risk factor from HCPCS code G0447 to both HCPCS codes GXXX2 and GXXX3, as we believe the same specialty mix will furnish these services. We request public comment on these proposed values for HCPCS codes GXXX2 and GXXX3.

4. Improving the Valuation and Coding of the Global Package

a. Overview

Since the inception of the PFS, we have valued and paid for certain services, such as surgery, as part of global packages that include the procedure and the services typically provided in the periods immediately before and after the procedure (56 FR 59502). For each of these codes (usually referred to as global surgery codes), we establish a single PFS payment that includes payment for particular services that we assume to be typically furnished during the established global period.

There are three primary categories of global packages that are labeled based on the number of post-operative days included in the global period: 0-day; 10-day; and 90-day. The 0-day global codes include the surgical procedure and the pre-operative and post-operative physicians' services on the day of the procedure, including visits related to the service. The 10-day global codes include these services and, in addition, visits related to the procedure during the 10 days following the procedure. The 90-day global codes include the same services as the 0-day global codes plus the pre-operative services furnished one day prior to the procedure and post-operative services during the 90 days immediately following the day of the procedure.

Section 40.1 of the Claims Processing Manual (Pub. 100–04, Chapter 12 Physician/Nonphysician Practitioners) defines the global surgical package to include the following services when furnished during the global period:

- Preoperative Visits—Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- Intra-operative Services—Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- Complications Following Surgery—All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications that do not require additional trips to the operating room;
- Postoperative Visits—Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- Postsurgical Pain Management—By the surgeon;
- Supplies—Except for those identified as exclusions; and

• Miscellaneous Services—Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

b. Concerns With the 10- and 90-Day Global Packages

CMS supports bundled payments as a mechanism to incentivize high-quality, efficient care. Although on the surface, the PFS global codes appear to function as bundled payments similar to those Medicare uses to make single payments for multiple services to hospitals under the inpatient and outpatient prospective payment systems, the practical reality is that these global codes function significantly differently than other bundled payments. First, the global surgical codes were established several decades ago when surgical follow-up care was far more homogenous than today. Today, there is more diversity in the kind of procedures covered by global periods, the settings in which the procedures and the follow-up care are furnished, the health care delivery system and business arrangements used by Medicare practitioners, and the care needs of Medicare beneficiaries. Despite these changes, the basic structures of the global surgery packages are the same as the packages that existed prior to the creation of the resource-based relative value system in 1992. Another significant difference between this and other typical models of bundled payments is that the payment rates for the global surgery packages are not updated regularly based on any reporting of the actual costs of patient care. For example, the hospital inpatient and outpatient prospective payment systems (the IPPS and OPPS, respectively) derive payment rates from hospital cost and charge data reported through annual Medicare hospital cost reports and the most recent year of claims data available for an inpatient stay or primary outpatient service. Because payment rates are based on consistently updated data, over time, payment rates adjust to reflect the average resource costs of current practice. Similarly, many of the new demonstration and innovation models track costs and make adjustments to payments. Another significant difference is that payment for the PFS global packages relies on valuing the combined services together. This means that there are no separate PFS values established for the procedures or the follow-up care, making it difficult to estimate the costs of the individual global code component services.

These unique characteristics have contributed to the significant and numerous concerns that have been raised regarding the accuracy of payment for global codes—especially those that include 10- and 90-day post-operative periods. In the following paragraphs, we address a series of concerns regarding these codes, including: the fundamental difficulties in establishing appropriate relative values for these packages, the potential inaccuracies in the current information used to price these services, the limitations on appropriate pricing in the future, the potential for these packages to create unwarranted payment differentials among specialties, the possibility that the current codes are incompatible with current medical practice, and the potential for these codes to present obstacles to the adoption of new payment models.

Independently, concerns such as these could be seen as issues that arise when developing many different payment mechanisms, for example: making fee-for-service payment rates, making single payments for multiple services, or paying practitioners for episodes of care over a period of time. However, in the case of the post-operative portion of the 10- and 90-day global codes, we believe these multi-layered concerns create substantial barriers to accurate valuation of these services relative to other PFS services.

(1) Fundamental Limitations in the Appropriate Valuation of the Global Packages With Post-Operative Days

In general, we face many challenges in valuing PFS services as accurately as possible. However, the unique nature of global surgery packages with 10- and 90-day post-operative periods presents additional challenges distinct from those presented in valuing other PFS services. Our valuation methodology for PFS services generally relies on assumptions regarding the resources involved in furnishing the "typical case" for each individual service unlike other payment systems that rely on actual data on the costs of furnishing services. Consistent with this valuation methodology, the RVUs for a global code should reflect the typical number and level of E/M services furnished in connection with the procedure. However, it is much easier to maintain relativity among the services that are valued on this basis when each of the services is described by codes of similar unit sizes. In other words, because codes with long post-operative periods include such a large number of services, any variations between the "typical" resource costs used to value the service and the actual resource costs associated with particular services are multiplied. The effects of this problem can be two-fold, skewing the accuracy of both the RVUs for individual global codes and the Medicare payment made to individual practitioners. The RVUs of the individual global service codes are skewed whenever there is any inaccuracy in the assumption of the typical number or kind of services in the post-operative periods. This inaccuracy has a greater impact than inaccuracies in assumptions for other PFS services because it affects a greater number of service units over a period of time than for individually priced services. Furthermore, in contrast to prospective payment systems, such inaccuracies under the PFS are not corrected over time through an annual ratesetting process that makes year-to-year adjustments based on data on actual costs. For example, if a 90-day global code is valued based on an assumption that ten post-operative visits is typical, but practitioners reporting the code typically only furnish six visits, then the resource assumptions are overestimated by the value of the four visits multiplied by the number of the times the procedure code is reported. In contrast, when our assumptions are incorrect about the typical resources involved in furnishing a PFS code that describes a single service, any inaccuracy in the RVUs is limited to the difference between the resource costs assumed for the typical service and the actual resource costs in furnishing one individual service. Such a variation between the assumptions used in calculating payment rates and the actual resource costs could be corrected if the payments for packaged services were updated regularly using data on actual services furnished. Although such a mechanism is common in other bundled payment systems, there is no such mechanism under the PFS. To make adjustments to the RVUs to account for inaccurate assumptions under the current PFS methodology, the global surgery code would need to be identified as potentially misvalued, survey data would have to reflect an accurate account of the number and level of typical post-operative visits, and we (with or without a corresponding recommendation from the RUC or others) would have to implement a change in RVUs based on the change in the number and level of visits to reflect the typical service.

These amplified inaccuracies may also occur whenever Medicare pays an individual practitioner reporting a 10- or 90-day global code. Practitioners may furnish a wide range of post-operative services to individual Medicare beneficiaries, depending on individual patient needs, changes in medical practice, and dynamic business models. Due to the way the 10- and 90-day global codes are constructed, the number and level of services included for purposes of calculating the payment for these services may vary greatly from the number and level of services that are actually furnished in any particular case. In contrast, the variation between the "typical" and the actual resource cost for the practitioner reporting an individually valued PFS services is constrained because the practitioner is only reporting and being paid for a specific service furnished on a particular date.

For most PFS services, any difference between the "typical" case on which RVUs are based and the actual case for a particular service is limited to the variation between the resources assumed to be involved in furnishing the typical case and the actual resources involved in furnishing the single specific service. When the global surgical package includes more or a higher level of E/M services than are actually furnished in the typical post-operative period, the Medicare payment is based on an overestimate of the quantity or kind of services furnished, not merely an overestimation of the resources involved in furnishing an individual service. The converse is true if the RVUs for the global surgical package are based on fewer or a lower level of services than are typically furnished for a particular code.

(2) Questions Regarding Accuracy of Current Assumptions

In previous rulemaking (77 FR 68911 through 68913), we acknowledged evidence suggesting that the values included in the post-operative period for global codes may not reflect the typical number and level of post-operative E/M visits actually furnished.

In 2005, the OIG examined whether global surgical packages are appropriately valued. In its report on eye and ocular surgeries, "National Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005" (A–05–07–00077), the OIG reviewed a sample of 300 eye and ocular surgeries, and counted the actual number of face-to-face services recorded in the patients' medical records to establish whether and, if so, how many post-operative E/M services were furnished by the surgeons. For about two-thirds of the claims sampled by the OIG, surgeons provided fewer E/M services in the post-operative period than were included in the global surgical package payment for each procedure. A small percentage of the surgeons furnished more E/M services than were included in the global surgical package payment. The OIG identified the number of face-to-face services recorded in the medical record, but did not review the medical necessity of the surgeries or the related E/M services. The OIG concluded that the RVUs for these global surgical packages are too high because they include a higher number of E/M services than typically are furnished within the global period for the reviewed procedures.

Following that report, the OIG continued to investigate E/M services furnished during global surgical periods. In May 2012, the OIG published a report entitled "Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided" (A–05–09–00053). For this investigation, the OIG sampled 300 musculoskeletal global surgeries and again found that, for the majority of sampled surgeries, physicians furnished fewer E/M services than were included as part of the global period payment for that service. Once again, a small percentage of surgeons furnished more E/M services than were included in the global surgical package payment. The OIG concluded that the RVUs for these global surgical packages are too high because they include a higher number of E/M services than typically are furnished within the global period for the reviewed procedures.

In both reports, the OIG recommended that we adjust the number of E/M services identified with the studied global surgical payments to reflect the number of E/M services that are actually being furnished. However, since it is not necessary under our current global surgery payment policy for a surgeon to report the individual E/M services actually furnished during the global surgical period, we do not have objective data upon which to assess whether the RVUs for global period surgical services reflect the typical number or level of E/M services that are furnished. In the CY 2013 PFS proposed rule (77 FR 44738), we previously sought public comments on collecting these data. As summarized in the CY 2013 PFS final rule (77 FR 68913) we did not discover a consensus among stakeholders regarding either the most appropriate means to gather the data, or the need for, or the appropriateness of using such data in valuing these services. In response to our comment solicitation, some commenters urged us to accept the RUC survey data as accurate in spite of the OIG reports and other concerns that have been expressed regarding whether the visits included in the global periods reflected the typical case. Others suggested that we should conduct new surveys using the RUC approach or that we should mine hospital data to identify the typical number of visits furnished. Some comments suggested eliminating the 10- and 90-day global codes.

(3) Limitations on Appropriate Future Valuations of 10- and 90-day Global Codes

Historically, our attempts to adjust RVUs for global services based on changes in the typical resource costs (especially with regard to site of service assumptions or changes to the number of post-surgery visits) have been difficult and controversial. At least in part, this is because the relationship between the work RVUs for the 10- and 90-day global codes (which includes the work RVU associated with the procedure itself) and the number of included post-operative visits in the existing values is not always clear. Some services with global periods have been valued by adding the work RVU of the surgical procedure and all pre- and post-operative E/M services included in the global period. However, in other cases, as many stakeholders have noted, the total work RVUs for surgical procedures and post-operative visits in global periods are estimated as a single value without any explicit correlation to the time and intensity values for the individual service components. Although we would welcome more objective information to improve our determination of the "typical" case, we believe that even if we engaged in the collection of better data on the number and level of E/M services typically furnished during the global periods for global surgery services, the valuation of individual codes with post-operative periods would not be straightforward. Furthermore, we believe it would be important to frequently update the data on the number and level of visits furnished during the post-operative periods in order to account for any changes in the patient population, medical practice, or business arrangements. Although such information would be available for developing payment rates for bundled services through other Medicare payment systems, practitioners paid through the PFS do not report such data.

(4) Unwarranted Payment Disparities

Subsequent to our last comment solicitation regarding the valuation of the post-operative periods (77 FR 68911 through 68913), some stakeholders have raised concerns that global surgery packages contribute to unwarranted payment disparities between practitioners who do and do not furnish these services. These stakeholders have addressed several ways the 10- and 90-day global packages may contribute to unwarranted payment disparities.

The stakeholders noted that, through the global surgery packages, Medicare pays practitioners who furnish E/M services during post-surgery periods regardless of whether the services are actually furnished, while practitioners who do not furnish global procedures with post-operative visits are only paid for E/M services that are actually furnished. In some cases, it is possible that the practitioner furnishing the global surgery procedure may not furnish any post-operative visits. Although we have policies to address the situation when post-operative care is transferred from one practitioner to another, the beneficiary might simply choose to seek care from another practitioner without a formal transfer of care. The other practitioner would then bill Medicare separately for E/M services for which payment was included in the global payment to the original practitioner. Those services would not have been separately billable if furnished by the original practitioner.

These circumstances can lead to unwarranted payment differences, allowing some practitioners to receive payment for fewer services than reflected in the Medicare payment. Practitioners who do not furnish global surgery services bill and are paid only for each individual service furnished. When global surgery values are based on inaccurate assumptions about the typical services furnished in the post-operative periods, these payment disparities can contribute to differences in aggregate RVUs across specialties. Since the RVUs are intended to reflect differences in the relative resource costs involved in furnishing a service, any disparity between assumed and actual costs results not only in paying some practitioners for some services that are not furnished, it also skews relativity between specialties.

Stakeholders have also pointed out that payment disparities can arise because E/M services reflected in global periods generally include higher PE values than the same services when billed separately. The difference in PE values between separately billed visits and those included in global packages result primarily from two factors that are both inherent in the PFS pricing methodology.

First, there is a different mix of PE inputs (clinical labor/supplies/equipment) included in the direct PE inputs for a global period E/M service and a separately billed E/M service. For example, the clinical labor inputs for separately reportable E/M codes includes a staff blend listed as "RN/LPN/MTA" (L037D) and priced at $0.37 per minute. Instead of this input, some codes with post-operative visits include the staff type "RN" (L051A) priced at a higher rate of $0.51 per minute. For these codes, the higher resource cost may accurately reflect the typical resource costs associated with those particular visits. However, the different direct PE inputs may drive unwarranted payment disparities among specialties who report global surgery codes with post-operative periods and those that do not. The only way to correct these potential discrepancies under the current system, which result from the specialty-based differences in resource costs, would be to include standard direct PE inputs for these services regardless of whether or not the standard inputs are typical for the specialties furnishing the services.

Second, the indirect PE allocated to the E/M visits included in global surgery codes is higher than that allocated to separately furnished E/M visits. This occurs because the range of specialties furnishing a particular global service is generally not as broad as range of specialties that report separate individual E/M services. Since the specialty mix for a service is a key factor in determining the allocation of indirect PE to each code, a higher amount of indirect PE can be allocated to the E/M services that are valued as part of the global surgery codes than to the individual E/M codes. Practitioners who use E/M codes to report visits separately are paid based on PE RVUs that reflect the amount of indirect PE allocated across a wide range of specialties, which has the tendency to lower the amount of indirect PE. For practitioners who are paid for visits primarily through post-operative periods, indirect PE is generally allocated with greater specificity. Two significant steps would be required to alleviate the impact of this disparity. First, we would have to identify the exact mathematical relationship between the work RVU and the number and level of post-operative visits for each global code; and second, we would have to propose a significant alteration of the PE methodology in order to allocate indirect PE that does not correlate to the specialties reporting the code in the Medicare claims data.

Furthermore, stakeholders have pointed out that the PE RVUs for codes with 10- or 90-day post-operative periods reflect the assumption that all outpatient visits occur in the higher-paid non-facility office setting, when many of these visits are likely to be furnished in provider-based departments, which would be paid at the lower, PFS facility rate if they were billable separately. As we note elsewhere in this proposed rule, we do not have data on the volume of physicians' services furnished in provider-based departments, but public information suggests that it is not insignificant and that it is growing. When these services are paid as part of a global package, there is no adjustment made based on the site of service. Therefore, even though the PFS payment for services furnished in post-operative global periods might include clinical labor, disposable supply, and medical equipment costs (and additional indirect PE allocation) that are incurred by the facility and not the practitioner reporting the service, the RVUs for global codes reflect all of these costs associated with the visits.

(5) Incompatibility of Current Packages With Current Practice and Unreliability of RVUs for Use in New Payment Models

In addition to these issues, the 10- and 90-day global periods reflect a long-established but no longer exclusive model of post-operative care that assumes the same practitioner who furnishes the procedure typically furnishes the follow-up visits related to that procedure. In many cases, we believe that models of post-operative care are increasingly heterogeneous, particularly given the overall shift of patient care to larger practices or team-based environments.

We believe that RVUs used to establish PFS payments are likely to serve as critical building blocks to developing, testing, and implementing a number of new payment models, including those that focus on bundled payments to practitioners or payments for episodes of care. Therefore, we believe it is critical for us to ensure that the PFS RVUs accurately reflect the resource costs for individual PFS services instead of reflecting potentially skewed assumptions regarding the number of services furnished over a long period of time in the "typical" case. To the extent that the 10- and 90-day global periods reflect inaccurate assumptions regarding resource costs associated with individual PFS services,

we believe they are likely to be obstacles to a wide range of potential improvements to PFS payments, including the potential incorporation of payment bundling designed to foster efficiency and quality care for Medicare beneficiaries.

c. Proposed Transition of 10- and 90-Day Global Packages Into 0-Day Global Packages

Although we have marginally addressed some of the concerns noted above with global packages in previous rulemaking, we do not believe that we have made significant progress in addressing the fundamental issues with the 10- and 90-day post-operative global packages. In the context of the misvalued code initiative, we believe it is critical for the RVUs used to develop PFS payment rates reflect the most accurate resource costs associated with PFS services. Based on the issues discussed above, we do not believe we can effectively address the issues inherent in establishing values for the 10- and 90-day global packages under our existing methodologies and with available data. As such, we do not believe that maintaining the post-operative 10-and 90-day global periods is compatible with our continued interest in using more objective data in the valuation of PFS services and accurately valuing services relative to each other. Because the typical number and level of post-operative visits during global periods may vary greatly across Medicare practitioners and beneficiaries, we believe that continued valuation and payment of these face-to-face services as a multi-day package may skew relativity and create unwarranted payment disparities within PFS payment. We also believe that the resource based valuation of individual physicians' services will continue to serve as a critical foundation for Medicare payment to physicians, whether through the current PFS or in any number of new payment models. Therefore, we believe it is critical that the RVUs under the PFS be based as closely and accurately as possible on the actual resources involved in furnishing the typical occurrence of specific services

To address the issues discussed above, we are proposing to retain global bundles for surgical services, but to refine bundles by transitioning over several years all 10- and 90-day global codes to 0-day global codes. Medically reasonable and necessary visits would be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure. We propose to make this transition for current 10-day global codes in CY 2017 and for the current 90-day global codes in CY 2018, pending the availability of data on which to base updated values for the global codes.

We believe that transitioning all 10- and 90-day global codes to 0-day global codes would:

- Increase the accuracy of PFS payment by setting payment rates for individual services based more closely upon the typical resources used in furnishing the procedures;
- Avoid potentially duplicative or unwarranted payments when a beneficiary receives post-operative care from a different practitioner during the global period;
- Eliminate disparities between the payment for E/M services in global periods and those furnished individually;
- Maintain the same-day packaging of pre- and post-operative physicians' services in the 0-day global; and
- Facilitate availability of more accurate data for new payment models and quality research.

As we transition these codes, we would need to establish RVUs that reflect the change in the global period for all the codes currently valued as 10- and 90-day global surgery services. We seek assistance from stakeholders on various aspects of this task. Prior to implementing these changes, we intend to gather objective data on the number of E/M and other services furnished during the current post-operative periods and use those data to inform both the valuation of particular services and the overall budget neutrality adjustments required to implement this proposal. We seek comment on the most efficient means of acquiring accurate data regarding the number of visits and other services actually being furnished by the practitioner during the current post-operative periods. For all the reasons stated above, we do not believe that survey data reflecting assumptions of the "typical case" meets the standards required to measure the resource costs of the wide range of services furnished during the post-operative periods. We acknowledge that collecting information on these services through claims submission may be the best approach, and we would propose such a collection through future rulemaking. However, we are also interested in alternatives. For example, we seek information on the extent to which individual practitioners or practices may currently maintain their own data on services furnished during the post-operative period, and how we might collect and objectively evaluate that data.

We also seek comment on the best means to ensure that allowing separate payment of E/M visits during post-operative periods does not incentivize otherwise unnecessary office visits during post-operative periods. If we adopt this proposal, we intend to monitor any changes in the utilization of E/M visits following its implementation but we are also seeking comment on potential payment policies that will mitigate such a change in behavior.

In developing this proposal, we considered several alternatives to the transformation of all global codes to 0-day global codes. First, we again considered the possibility of gathering data and using the data to revalue the 10- and 90- day global codes. While this option would have maintained the status quo in terms of reporting services, it would have required much of the same effort as this proposal without alleviating many of the problems associated with the 10- and 90-day global periods. For example, collecting accurate data would allow for more accurate estimates of the number and kind of visits included in the post-operative periods at the time of the survey. However, this alternative approach would only mitigate part of the potential for unwarranted payment disparities. For example, the values for the visits in the global codes would continue to include different amounts of PE RVUs than separately reportable visits and would continue to provide incentives to some practitioners to minimize patient visits. Additionally, it would not address the changes in practice patterns that we believe have been occurring whereby the physician furnishing the procedure is not necessarily the same physician conducting the post-procedure follow up.

This alternative option would also rest extensively on the effectiveness of using the new data to revalue the codes accurately. Given the unclear relationship between the assigned work RVUs and the post-operative visits across all of these services, incorporating objective data on the number of visits to adjust work RVUs would still necessitate extensive review of individual codes or families of codes by CMS and stakeholders, including the RUC. We believe the investment of resources for such an effort would be better made to solve a broader range of problems.

We also considered other possibilities, such as altering our PE methodology to ensure that the PE inputs and indirect PE for visits in the global period were valued the same as

separately reportable E/M codes or requiring reporting of the visits for all 10- and 90-day global services while maintaining the 10- and 90-day global period payment rates. However, we believe this option would require all of the same effort by practitioners, CMS, and other stakeholders without alleviating most of the problems addressed in the preceding paragraphs.

We also considered maintaining the status quo and identifying each of the 10- and 90-day global codes as potentially misvalued through our potentially misvalued code process for review as 10 and 90 day globals. Inappropriate valuations of these services has a major effect on the fee schedule due to the percentage of PFS dollars paid through 10- and 90-day global codes (3 percent and 11 percent, respectively), and thus, valuing them appropriately is critical to appropriate valuation and relativity throughout the PFS. Through the individual review approach, we could review the appropriateness of the global period and the accurate number of visits for each service. Yet revaluing all 3,000 global surgery codes through the potentially misvalued codes approach would not address many of the problems identified above. Unless such an effort was combined with changes in the PE methodology, it would only partially address the valuation and accuracy issues and would leave all the other issues unresolved. Moreover, the valuation and accuracy issues that could be addressed through this approach would rapidly be out of date as medical practice continues to change. Therefore, such an approach would be only partially effective and would impede our ability to address other potentially misvalued codes.

We seek stakeholder input on an accurate and efficient means to revalue or adjust the work RVUs for the current 10- and 90-day global codes to reflect the typical resources involved in furnishing the services including both the pre- and post-operative care on the day of the procedure. We believe that collecting data on the number and level of post-operative visits furnished by the practitioner reporting current 10-and 90-day global codes will be essential to ensuring work RVU relativity across these services. We also believe that these data will be necessary to determine the relationship between current work RVUs and current number of post-operative visits, within categories of codes and code families. However, we believe that once we collect those data, there are a wide range of possible approaches to the revaluation of the large number of individual global services, some of which may deviate from current processes like those undertaken by the RUC. To date, the potentially misvalued code initiative has focused on several hundred, generally high-volume codes per year. This proposal requires revaluing a larger number of codes over a shorter period of time and includes many services with relatively low volume in the Medicare population. Given these circumstances, it does not seem practical to survey time and intensity information on each of these procedures. Absent any new survey data regarding the procedures themselves, we believe that data regarding the number and level of post-service office visits can be used in conjunction with other methods of valuation, such as:

- Using the current potentially misvalued code process to identify and value the relatively small number of codes that represent the majority of the volume of services that are currently reported with codes with post-operative periods, and then adjusting the aggregate RVUs to account for the number of visits and using magnitude estimation to value the remaining services in the family;
- Valuing one code within a family through the current valuation process and then using magnitude estimation to value the remaining services in the family;
- Surveying a sample of codes across all procedures to create an index that could be used to value the remaining codes.

While we believe these are plausible options for the revaluation of these services, we believe there may be others. Therefore, we seek input on the best approach to achieve this proposed transition from 10- and 90-day, to 0-day global periods, including the timing of the changes, the means for revaluation, and the most effective and least burdensome means to collect objective, representative data regarding the actual number of visits currently furnished in the post-operative global periods. We also seek comment on whether the effective date for the transition to 0-day global periods should be staggered across families of codes or other categories. For example, while we are proposing to transition 10-day global periods in 2017 and 90-day global periods in 2018, we seek comment on whether we should consider implementing the transition more or less quickly and over one or several years. We also seek comment regarding the appropriate valuation of new, revised, or potentially misvalued 10- or 90-day global codes before implementation of this proposal.

5. Improving the Valuation of the Global Package

In the CY 2013 proposed rule, we sought comments on methods of obtaining accurate and current data on E/M services furnished as part of a global surgical package. In addition to receiving the broader comments on measuring post-operative work, we also received a comment from the RUC saying that the hospital inpatient and discharge day management services included in the global period for many surgical procedures were inadvertently removed from the time file in 2007. With its comment letter, the RUC sent us a data file with updated times for these post-operative visits for some services that displayed zero hospital inpatient or discharge day visits in the CMS time file. After extensive review, we concluded that the data were deleted from the time file due to an inadvertent error as noted by the RUC. Therefore, during CY 2014 PFS rulemaking we finalized a proposal to replace the missing postoperative hospital inpatient and discharge day visits for the more than 100 codes that were identified by the RUC.

Since then, the AMA has identified additional codes with data in the work time file that reflects a similar error. Since we believe these global surgery codes are missing postoperative hospital inpatient and discharge day visits due to an inadvertent error, we are proposing to include a corrected number of visits for the codes displayed in Table 11. This proposal would also alter the total time associated with the codes in the work time file.

TABLE 11—PROPOSED WORK TIME CHANGES IN SELECTED GLOBAL SURGICAL PACKAGE VISITS

CPT code	Short descriptor	Visits included in Global Package						CY 2014 time	CY 2015 time
		99231	99232	99233	99238	99291	99292		
19367	Breast reconstruction	3.00			1.00			552.00	590.00
20802	Replantation arm complete	6.00			1.00			1047.00	1041.00
20805	Replant forearm complete	6.00			1.00			1017.00	1012.00
20808	Replantation hand complete	5.00			1.00			1177.00	1112.00
20972	Bone/skin graft metatarsal	5.00			1.00			918.00	898.00
21137	Reduction of forehead				1.00			272.00	310.00
21138	Reduction of forehead				1.00			362.00	400.00
21150	Lefort ii anterior intrusion	1.00			1.00	1.00		542.00	623.00
21159	Lefort iii w/fhdw/o lefort i	3.00			1.00	2.00		784.00	986.00
21160	Lefort iii w/fhd w/lefort i		2.50		1.00	2.50		844.00	1121.00
21172	Reconstruct orbit/forehead		1.50		1.00	1.50		474.00	641.00
21175	Reconstruct orbit/forehead		1.00		1.00	2.00		767.00	731.00
21179	Reconstruct entire forehead				1.00	2.00		412.00	590.00
21180	Reconstruct entire forehead				1.00	2.00		492.00	670.00
21181	Contour cranial bone lesion	1.00			1.00			338.00	396.00
21182	Reconstruct cranial bone		1.00		1.00	2.00		856.00	801.00
21183	Reconstruct cranial bone		2.00		1.00	2.00		669.00	891.00
21184	Reconstruct cranial bone		2.00		1.00	2.00		774.00	996.00
22102	Remove part lumbar vertebra	3.00			1.00			392.00	387.00
22310	Closed tx vert fx w/o manj	3.50			1.00			167.00	236.00
28122	Partial removal of foot bone				1.00			230.00	249.00
33470	Revision of pulmonary valve	1.50			1.00	3.50		890.00	769.00
33471	Valvotomy pulmonary valve	4.00			1.00	1.00		603.00	572.00
33476	Revision of heart chamber				1.00	5.00		725.00	859.00
33478	Revision of heart chamber				1.00	5.00		740.00	882.00
33610	Repair by enlargement	7.00			1.00			770.00	648.00
33720	Repair of heart defect				1.00	4.00		633.00	770.00
33737	Revision of heart chamber	2.00			1.00	3.00		603.00	706.00
33755	Major vessel shunt	1.50			1.00	3.50		680.00	750.00
33762	Major vessel shunt	1.50			1.00	3.50		740.00	755.00
33766	Major vessel shunt	1.50			1.00	3.50		740.00	756.00
33775	Repair great vessels defect	0.50			1.00	6.50		860.00	1043.00
33776	Repair great vessels defect	1.50			1.00	6.50		950.00	1096.00
33777	Repair great vessels defect	3.50			1.00	4.50		950.00	993.00
33813	Repair septal defect	1.00			1.00	3.00		603.00	664.00
33814	Repair septal defect				1.00	5.00		710.00	838.00
33822	Revise major vessel				1.00	2.00		430.00	463.00
50360	Transplantation of kidney	1.00	2.00	2.00	1.00			664.00	774.00
61556	Incise skull/sutures	3.00	3.00	1.00	1.00			749.00	692.00
61558	Excision of skull/sutures	5.00			1.00			669.00	661.00
61559	Excision of skull/sutures	4.00			1.00			662.00	665.00
61563	Excision of skull tumor	1.00	2.00	1.00	1.00			762.00	656.00
61564	Excision of skull tumor	4.00			1.00			629.00	623.00
61580	Craniofacial approach skull		3.00	4.00	1.00	1.00		1313.30	1078.30
61581	Craniofacial approach skull	1.00	1.00	5.00	1.00	1.00		1419.40	1214.40
61582	Craniofacial approach skull	4.00	3.00	1.00	1.00	1.00		1185.30	1010.30
61583	Craniofacial approach skull	8.00		1.00	1.00	1.00		1100.40	906.40
61584	Orbitocranial approach/skull	2.00	3.00	2.00	1.00	1.00		1066.40	842.40
61585	Orbitocranial approach/skull	1.00	3.00	3.00	1.00	2.00		1377.70	1101.70
61590	Infratemporal approach/skull	1.00		7.00	1.00	2.00		1732.40	1418.40
61591	Infratemporal approach/skull	3.00	4.00		1.00	2.00		1478.85	1254.85
61592	Orbitocranial approach/skull	1.00	3.00	2.00	1.00	2.00		1256.80	1002.80
61595	Transtemporal approach/skull		3.00	4.00	1.00	1.00		1312.80	1077.80

TABLE 11—PROPOSED WORK TIME CHANGES IN SELECTED GLOBAL SURGICAL PACKAGE VISITS—Continued

CPT code	Short descriptor	Visits included in Global Package						CY 2014 time	CY 2015 time
		99231	99232	99233	99238	99291	99292		
61596	Transcochlear approach/skull	1.00	4.00	3.00	1.00	1.00		1442.30	1188.30
61597	Transcondylar approach/skull	5.00	2.00	1.00	1.00	2.00		1284.40	1041.40
61598	Transpetrosal approach/skull	2.00	3.00	1.00	1.00	2.00		1253.10	1048.10
61600	Resect/excise cranial lesion			6.00	1.00	1.00		1328.40	1101.40
61601	Resect/excise cranial lesion	2.00	2.00	2.00	1.00	2.00		1078.90	854.90
61605	Resect/excise cranial lesion	3.00	2.00	1.00	1.00	2.00		1238.60	1052.60
61606	Resect/excise cranial lesion	3.00	3.00	1.00	1.00	2.00		1161.90	926.90
61607	Resect/excise cranial lesion		1.00	6.00	1.00	2.00		1526.20	1201.20
61608	Resect/excise cranial lesion	3.00	3.00	2.00	1.00	2.00		1326.00	1042.00
61613	Remove aneurysm sinus	1.00		6.00	1.00	2.00		1416.00	1102.00
61615	Resect/excise lesion skull	2.00	4.00	2.00	1.00	1.00		1327.20	1092.20
61616	Resect/excise lesion skull	5.00	2.00	1.00	1.00	2.00		1329.80	1116.80
61618	Repair dura		1.00	2.00	1.00			647.10	573.10
61619	Repair dura	1.00	2.00	1.00	1.00			683.60	587.60
62115	Reduction of skull defect	4.50			1.00			672.00	678.00
62116	Reduction of skull defect	1.00	2.00	1.00	1.00			737.00	616.00
62117	Reduction of skull defect		2.00	2.00	1.00			854.00	714.00
62120	Repair skull cavity lesion	3.00			1.00			512.00	523.00