SUMMARY OF AAO-HNS RUC & CPT EFFORTS FOR CY 2014

Results of 2014 Refinement Panels and AAO-HNS Comments on 2014 final rule:
The Academy participated in one refinement panel as a “related specialty” for CY 2014. While we did not serve as the presenting specialty, we supported Gastroenterology’s requested revisions to values for CPT 43204, 43205, and 43233. CMS did not elect to increase the values for two of the three services based on the information provided during refinement; however, they did increase the value for 43233. The final 2015 work RVUs for these codes will now be as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>43204</td>
<td>Injectoin of dialted esophageal veins using an endoscope</td>
<td>2.40</td>
<td>2.89</td>
<td>2.77</td>
<td>2.40</td>
</tr>
<tr>
<td>43205</td>
<td>Tying of esophageal veins using endoscope</td>
<td>2.51</td>
<td>3.00</td>
<td>2.88</td>
<td>2.51</td>
</tr>
<tr>
<td>43233</td>
<td>Balloon dilation of esophagus, stomach, and/or upper small</td>
<td>4.05</td>
<td>4.45</td>
<td>4.26</td>
<td>4.26</td>
</tr>
</tbody>
</table>

The Academy previously commented on several CY 2014 interim work values for ENT services in our 2014 final MPFS comment letter to CMS, including 43191-43198 rigid transoral esophagoscopy and TNE codes, several flexible transoral esophagoscopy codes, CPT 69210 removal impacted cerumen, and several speech evaluation codes (92521-92524).

Based on Academy comments, CMS elected to increase the final 2015 work RVUs for all six rigid esophagoscopy codes, both TNE codes, and several of the flexible esophagoscopy codes.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>2014 interim wRVU</th>
<th>2015 finalized wRVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>43191</td>
<td>2.00</td>
<td>2.49</td>
</tr>
<tr>
<td>43192</td>
<td>2.45</td>
<td>2.79</td>
</tr>
<tr>
<td>43193</td>
<td>3.00</td>
<td>2.79</td>
</tr>
<tr>
<td>43194</td>
<td>3.00</td>
<td>3.51</td>
</tr>
<tr>
<td>43195</td>
<td>3.30</td>
<td>3.07</td>
</tr>
<tr>
<td>43196</td>
<td>1.48</td>
<td>3.31</td>
</tr>
<tr>
<td>43197</td>
<td>1.78</td>
<td>1.52</td>
</tr>
<tr>
<td>43198</td>
<td>1.50</td>
<td>1.82</td>
</tr>
<tr>
<td>43200</td>
<td>1.80</td>
<td>1.52</td>
</tr>
<tr>
<td>43202</td>
<td>2.51</td>
<td>1.82</td>
</tr>
<tr>
<td>43215</td>
<td>2.34</td>
<td>2.54</td>
</tr>
</tbody>
</table>

CMS outlined the following as their basis for these value modifications: “we agree that modification of the CY 2014 interim final values is appropriate. Based upon the information provided in comments and further investigation, we believe that greater intensity is involved in furnishing rigid than flexible transoral
esophagoscopy. Accordingly, rather than assigning 1 work RVU per 10 minutes of intraservice time as we did for the CY 2014 interim final, we are assigning a final work RVU to the base code, CPT code 41391, of 2.49. This work RVU is based on increasing the work RVU of the previous comparable code (1.59) to reflect the percentage increase in time for the CY 2014 code. For the remaining rigid esophagoscopy codes, we developed RVUs by starting with the RVUs for the corresponding flexible esophagoscopy codes, and increasing those values by adding the difference between the base flexible esophagoscopy and the base rigid esophagoscopy codes to arrive at final RVUs. We are establishing a final work RVU of 2.79 to CPT code 43192, 2.79 to CPT code 43193, 3.51 to CPT code 43194, 3.07 to CPT code 43195, and 3.31 to CPT code 43196. These codes were not referred to refinement because the request did not meet the criteria for referral.” Related to the TNE codes, CMS stated: “After consideration of the comments, we agree that the work RVUs for these codes should not be reduced because moderate sedation is not typically used. Accordingly, we agree with the RUC recommendation to assign the same work RVUs to these codes as to CPT code 43200 (Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed) and 43202 (Esophagoscopy, flexible, transoral; with biopsy, single or multiple) the comparable transoral codes.”

Cerumen removal: Within the 2014 final rule CMS stated that they would not pay for 69210 at the typical 150% payment rate when performed bilaterally. In response, the Academy commented in our letter to CMS on the final rule, convened a call with CMS to further discuss our concerns related to this issue, and surveyed our members regarding how often they perform the service bilaterally (the results of which were shared with CMS in early 2014). CMS stated they were implementing this payment policy due to their belief that this service would almost always be performed bilaterally. This theory was somewhat supported by the survey conducted by AAO-HNS, which indicated of 121 respondents, 60% typically perform this service on both ears on one date of service.

Within the 2015 final rule, CMS addressed the Academy’s comments asking them to rescind this policy due to confusion it has caused coders and physicians based on the descriptor stating that this service is “unilateral.” CMS responded stating, “We continue to believe that the procedure will be furnished in both ears as the physiologic processes that create cerumen impaction likely would affect both ears. As a result, we will continue to allow only one unit of CPT 69210 to be billed when furnished bilaterally and are finalizing our CY 2014 interim final work RVU for this service.”

Speech evaluation codes: CMS did not modify the final values for speech evaluation codes (92521-92524) as requested by the Academy and other audiology specialty societies. In response to comments that these services were undervalued by CMS in the 2014 final rule CMS stated: “We believe that our interim final work RVU is most appropriate for these services. In the HCPAC recommendation for CPT code 92523 the affected specialty society stated that its survey results were faulty for this CPT code because those surveyed did not consider all the work necessary to perform the service. The commenters did not provide any information that demonstrates that our valuations fail to fully account for the intensity, work, and time required to perform these services. Therefore, we are finalizing our CY 2014 interim final values for CY 2015. We did not refer these codes to refinement because the request did not meet the criteria for refinement.”

Academy comments related to practice expense

TNE codes: We commented that it was inappropriate not to include any clinical staff time for cleaning these instruments. In addition, we disagreed with CMS’ decision to delete the biopsy forceps for CPT 43198, as the CPT descriptor for this code clearly states that a biopsy is performed as part of this service. Thus, for this code to be appropriately used by the surgeon, and for the work of removing to be completed, biopsy forceps are mandatory to properly perform the procedure and should be retained in the direct practice expense for CPT 43198.

CMS responded to the request for cleaning time by stating: “In general, as a matter of relativity throughout the PFS, the time allocated for the standard clinical labor task “Clean room/equipment following procedure” encompasses time for cleaning all equipment items. The only exceptions to this rule are for equipment items that are tied to specific clinical labor tasks, such as cleaning the surgical instrument pack or cleaning a scope. We do not believe it would serve relativity to separately break out time to clean various different types of equipment.” Related to the forceps they responded: “For the biopsy forceps, we indicated in the final rule with comment period that the information included with the RUC recommendation suggested that the biopsy forceps was reusable (as suggested by the
cleaning time mentioned in this comment). As such, we have created a new equipment item based on the invoice provided with the recommendation and assigned 46 minutes to this equipment item. However, since we did not receive a paid invoice with this item, we will price it at $0 until we receive a paid invoice.

**Academy comments related to Malpractice Crosswalks**

Within our comments on the 2014 final rule, we noted that we disagreed with CMS’ assigned malpractice RVU crosswalk for the rigid transoral esophagoscopy codes to set the Malpractice RVUs for these services. CMS utilized CPT 31575 flexible laryngoscopy as the malpractice crosswalk, despite our recommended crosswalk to CPT 31622 Bronchoscopy, rigid or flexible. **Within the 2015 final rule CMS acknowledged our comment in this regard, but reiterated their position that CPT 31575 was the most appropriate crosswalk and stated they will maintain this as the final Malpractice RVU crosswalk for these services.**

**Interim Values for AAO-HNS RUC Reviewed Codes Published in 2015 Final Rule**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>CY 2014 RVU</th>
<th>AMA RUC Recommended RVU</th>
<th>CY 2014 Interim RVU</th>
<th>Agree/Disagree with AMA RVU Recommended RVU</th>
<th>CMS Time refinement</th>
</tr>
</thead>
<tbody>
<tr>
<td>43180</td>
<td>Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (e.g., Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed</td>
<td>New</td>
<td>9.03</td>
<td>9.03</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>92540</td>
<td>Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording</td>
<td>1.50</td>
<td>1.50</td>
<td>1.50</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>92541</td>
<td>Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording</td>
<td>.40</td>
<td>.40</td>
<td>.40</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>92542</td>
<td>Positional nystagmus test, minimum of 4 positions, with recording</td>
<td>.33</td>
<td>.48</td>
<td>.48</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>92543</td>
<td>Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording</td>
<td>.10</td>
<td>.35</td>
<td>.10</td>
<td>(code revised this year and being resurveyed for Jan 2015)</td>
<td>No</td>
</tr>
<tr>
<td>92544</td>
<td>Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording</td>
<td>.26</td>
<td>.27</td>
<td>.27</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>92545</td>
<td>Oscillating tracking test, with recording</td>
<td>.23</td>
<td>.27</td>
<td>.27</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

CMS approved our PE and requested PLI crosswalks for these codes as well in the 2015 final rule.
OPPS CAP PE Review (14 codes)
In response to the 2014 rulemaking where CMS identified concerns over services that were paid more in the physician office than the facility setting due to high cost supplies or equipment, the AMA issued a screen for the 211 codes which were captured by the OPPS CAP list identified by CMS. During the April 2014 RUC, the Academy elected to review the 14 ENT codes captured on this screen issued by the RUC. The PE for all 14 codes was presented to the RUC and recommendations were sent on to CMS for inclusion in the final 2015 rule. Despite this, CMS did not include any information from those recommendations, and in fact, does not even recognize that these services were reviewed, within the content of the 2015 final MPFS. As such, CMS did not modify any of the PE inputs for these 14 ENT codes. Staff reached out to the AMA regarding this issue and the AMA confirmed that CMS intentionally did not include this information within the rule. We will comment on this issue in our letter submitted by December 30th, to CMS.

Within the final rule, CMS revisits their CY 2014 proposed policy to limit the non facility PE RVUs for individual codes so that the total non facility PFS payment amount would not exceed the total combined amount that Medicare would pay for the same code in the facility setting. CMS adds that it is not proposing a similar policy for the CY 2015 PFS and that if it did do so in the future rulemaking, it would consider all of the comments received previously. CMS notes, however, that it continues to believe that there are various possibilities for leveraging the use of available hospital cost data in the PE RVU methodology to ensure that the relative costs for PFS services are developed using data that is auditable and comprehensively and regularly updated. CMS adds that section 220(a) of PAMA, Publ. L. 113-93, provides them with the authority to exploring ways of collecting better and updated resource data from physician practices, including those that are provider-based, and other non-facility entities paid under the PFS, and that using this information does not detract from the statutorily required “relativity” of the MPFS. CMS says that such efforts will be challenging given the wide variety of practices and likely impose some burden on EPs. CMS notes that through a validation contract, it has been gathering time data directly from physician practices, from which it has learned much about the challenges of gathering data directly from physician practices.

CMS further notes that section 220 of PAMA provides authority to use alternative approaches to establish PE RVUs, including the use of data from other suppliers and providers, and that the agency is exploring how best to exercise this authority. They note that they continue to believe that there are various possibilities for leveraging the use of available hospital cost data in the PE RVU methodology to ensure that the relative costs for PFS services are developed using data that is auditable and comprehensively and regularly updated. They feel that OPPS cost data is routinely updated and is an auditable resource cost information submitted contemporaneously by a wide array of providers across the country, and therefore, is a valid reflection of “relative” resources and could be useful to supplement the resource cost information developed under our current methodology based upon a typical case that are developed with information from a small number of representative practitioners for a small percentage of codes in any particular year. They note that their own experience has shown that is difficult to obtain invoices for supply and equipment items that we can use in pricing direct PE inputs. Many specialty societies also have noted the challenges in obtaining recent invoices for medical supplies and equipment. Further, PE calculations rely heavily on information from the Physician Practice Expense Information Survey (PPIS) survey, which, as discussed earlier, was conducted in 2007 and 2008. When we implemented the results of the survey, many in the community expressed serious concerns over the accuracy of this or other PE surveys as a way of gathering data on PE inputs from the diversity of providers paid under the PFS. They note that the OPPS pricing information could be as a means to validate or, perhaps, in setting the relative resource cost assumptions within the PFS PE methodology.

Transition from Film to Digital Direct PE Inputs
CMS finalized their proposal to convert existing PE inputs for CPT codes that utilize a PACS system from the existing input that is now outmoded, to that of a digital PE input replacement. Since the RUC did not provide CMS with paid invoices for PACS systems, CMS has finalized their proposal to use a desktop computer (ED021) as a proxy for the PACS workstation as a direct expense. Specifically, for the 31 services that already contain ED021 (computer, desktop, w- monitor), we proposed to retain the time that is currently included in the direct PE input database. For the remaining services that are valued in the nonfacility setting, we proposed to allocate the full clinical labor intraservice time to ED021, except for codes without clinical labor, in which case we proposed to allocate the intraservice work time to ED021. For services valued only in the facility setting, we proposed to allocate the post-service clinical labor time to ED021, since the film supply and/or equipment inputs were previously associated with the post-service period. This impacted the following ENT services: CPT 61580, 61581, 92521, 92523, 92524, 92601, 92603, 92611, 92612, 92614, 92616, 95800, 95801.
Collecting Data on Off-Campus Provider-Based Outpatient Departments

CMS also continues to seek a better understanding regarding the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments. CMS adds that as more physician practices become hospital-based, it is difficult to know which PE costs typically are actually incurred by the physician, which are incurred by the hospital, and whether Medicare’s bifurcated site-of-service differential adequately accounts for the typical resource costs given these relationships. **CMS finalized two policy changes within the final rule to address these concerns.**

1) They finalized two new place of service (POS) codes (one for outpatient services furnished on-campus, remote, or satellite locations of a hospital, and a second to identify services furnished in off-campus hospital provider-based outpatient department) to replace POS 22 (Hospital outpatient). There will be no voluntary reporting period for these codes, but CMS intends to do education prior to their release and expect them to be available after July 1, 2015.

2) for hospital claims they are creating a HCPCS modifier that must be reported with every code for outpatient hospital services furnished in an off-campus PBD of a hospital. This is not required for remote locations or satellite facilities of a hospital, or for services furnished in an ED. The modifier will be available as of January 1, 2015 with the label “PO”. **Reporting of the modifier will be voluntary for one year and required beginning on January 1, 2016.**

Potentially Misvalued Services Under the Fee Schedule (p. 202)

In recent years CMS and the AMA Relative Update Committee (RUC) have taken increasingly significant steps to address potentially misvalued codes. Most recently, section 1848(c)(2)(K)(ii) of the Act (as added by section 3134 of the ACA directed the Secretary to specifically examine potentially misvalued services in seven categories:

1. Codes and families of codes for which there has been the fastest growth,
2. Codes or families of codes that have experienced substantial changes in practice expenses,
3. Codes that are recently established for new technologies or services,
4. Multiple codes that are frequently billed in conjunction with furnishing a single service,
5. Codes with low relative values, particularly those that are often billed multiple times for a single treatment,
6. Codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'), and
7. Other codes determined to be appropriate by the Secretary.

In addition, 2014 legislation, the Protecting Access to Medicare Act (PAMA)), authorized the Secretary to collect or obtain information from any eligible professional (EP) or any other source on the resources directly or indirectly related to furnishing services for which payment is made under the PFS. This information can be collected or obtained through surveys of physicians or other supplies, providers of services, manufacturers, and vendors; surgical logs, billing systems or other practice or facility records, EHRs; and any other mechanism determined appropriate by the Secretary. **If CMS uses this information they are required to disclose the sources of the information via rulemaking.** The PAMA also added nine new categories that the Secretary must consider in identifying potentially misvalued codes:

1. Codes that account for the majority of spending under the PFS
2. Codes for services that have experienced a substantial change in the hospital length of stay or procedure time
3. Codes for which there may be a change in the typical site of service since the code was last valued
4. Codes for which there is a significant difference in payment for the same service between different sites of service
5. Codes for which there may be anomalies in RVUS within a family of codes
6. Codes for services where there may be efficiencies when a service is furnished at the same time as other services
7. Codes with high intra-service work per unit of time (IWPUT)
8. Codes with high PE RVUs
9. Codes with high cost supplies
In CY 2013, CMS finalized their policy to allow public nomination of potentially misvalued codes which should be considered for review. Within the 2015 proposed rule two codes were nominated by the public as potentially misvalued / requiring review. Notably, one was CPT 41530 Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session, which was nominated by the Academy during 2014 notice and comment periods. The Academy felt that based on input from members and review by experts of the Sleep Committee and other stakeholders that two of the practice expense inputs in the existing code had become outdated and required refinement based on current pricing and technology utilized for this procedure. In our comments on the NPRM, we noted that these concerns had been addressed by a review of the PE for 41530 during the April RUC meeting and therefore, additional review was not necessary. CMS responded in the final rule and stated, “The RUC only provided us with recommendations for PE inputs for CPT code 41530. Under our usual process, we value work and PE at the same time and would expect to receive RUC recommendations on both before we revalue this service. We disagree with the commenter’s statement that codes that may save money for the Medicare program should not be considered as potentially misvalued. Our aim, consistent with our statutory directive, is to value all services appropriately under the PFS to reflect the relative resources involved in furnishing them. After consideration of public comments, we are finalizing CPT code 41530 as potentially misvalued.” This essentially means that CMS is requiring 41530 to be fully surveyed.

Further, CMS proposed a new screen which captures approximately 65 codes listed below as potentially misvalued codes as a prioritized subset of codes that account for the majority of spending under the physician fee schedule. Specifically, they note that within their usual identification process for capturing potentially misvalued codes it is possible to miss certain services that are important to a segment of Medicare practitioners and beneficiaries because the specialty that typically furnishes the service does not have high volume relative to the overall PFS utilization. To capture such services in developing this list, they began by identifying the top 20 codes by specialty in terms of allowed charges. They excluded codes from our proposed potentially misvalued list reviewed since CY 2009, with fewer than $10 million in allowed charges, and that describe anesthesia or E/M services. Within the final rule, however, CMS rescinded this screen as a result of their decision to finalize the transition of all codes to 000 globals by 2018. Rather, they directed that the RUC should focus their efforts on how to operationalize that policy change, and delayed this screen and review of associated codes to a time uncertain. The codes relevant to Otolaryngology that were captured in this screen are listed below. Review of codes in red has been cancelled, or postponed, based on the delay of the screen.

- 11100 Biopsy skin lesion
- 11101 Biopsy skin add-on
- 14060 Tis trnfr e/u/e/l 10 sq cm/<
- 31575 Diagnostic laryngoscopy
- 31579 Diagnostic laryngoscopy
- 92557 Comprehensive hearing test
- 95004 Percut allergy skin tests
- 95165 Antigen therapy services

Timeline for Valuing New, Revised, and Potentially Misvalued Codes – Publishing proposed values in the NPRM (p. 202)

In the CY 2012 rulemaking process, CMS proposed and finalized consolidation of the five-year review and the potentially misvalued code activities into an annual review of potentially misvalued codes. Under this process, CMS issues interim final RVUs for all revaluations and new codes in the PFS final rule with comment period and payments are based on those values during the CY covered by the final rule. CMS considers it appropriate to establish interim values for new, revised and potentially misvalued codes because of the timing incongruities between the PFS rulemaking cycle and the release of codes by the AMA CPT Editorial Panel and the RUC review process.

CMS notes that their recent revaluation of several code families have raised concerns from stakeholders with the existing process based on the reductions in payment for those services. Specifically, that they did not receive notice of the possible reductions before they occurred, CMS notes that stakeholders should be aware of changes because either CPT has made changes or CMS has identified the codes as potentially misvalued, and representatives of the affected specialties
are participating in the RUC meetings. Commenters have asserted, however, they are not aware of RUC recommendations, they have no opportunity to respond to RUC recommendations and not all suppliers are permitted to participate in the RUC process. Additionally, some stakeholders objected to interim final decisions because they do not have an opportunity to meaningfully comment before the values are implemented in the next year’s final rule.

**In response to these concerns, CMS issued several proposals to modify the process of finalizing values for new and revised services via rulemaking each year. Based on comments received, they have elected to finalize the following:**

- 2016 will be a transition year during which they will propose values for new, revised, and potentially misvalued codes that they receive RUC recommendations in time for inclusion in the 2016 NPRM. For all others, they will establish interim final values in the 2016 final rule as they have historically done.
- In 2017, CMS will include proposed values for all codes for which CMS has complete RUC recommendations by **February 10th** of the preceding year. This will allow for stakeholder comment on the proposed values within the proposed rule notice and comment period, annually. For codes where CMS does not receive a RUC recommendation by the deadline, CMS will use G-codes in order to facilitate continued payment for certain services (those with predecessor codes) for which we do not receive RUC recommendations in time to propose values; and adopt interim final values in the case of wholly new services, for which there are no predecessor codes or values, and for which we do not receive RUC recommendations in time to propose values.

**Refinement Panels**

Within the NPRM, CMS proposed to eliminate the refinement panel process given that under the new structure outlined above, stakeholders would have the opportunity to comment on proposed values prior to them becoming finalized for the following year. CMS noted that they received a number of comments criticizing the refinement panel process, but overall were encouraged to retain it as a method of “appeal” for stakeholders. CMS clarifies in the final rule that the purpose of the refinement panel is to give them additional information to consider in exercising our responsibility to establish appropriate RVUs for Medicare services. Like many of the commenters, CMS agreed the refinement panel is not achieving its purpose and often reiterates the issues raised and information discussed at the RUC. Since CMS had access to this information at the time interim final values were established, it seems unlikely that a repeat discussion of the same issues would lead them to change valuations based upon information that already had been carefully considered. **However, in light of the significant concerns raised by commenters, CMS did not finalize their proposal to eliminate the refinement panel.** They stated they will explore ways to address the many concerns that they, and stakeholders, have about the refinement panel process and whether the change in process eliminates the need for a refinement panel.

**Improving Valuation of the Global Surgical Package – Concerns with 010 and 090 Globals (p. 127)**

Within the 2015 NPRM, CMS proposed a major change to reporting global surgical procedures by suggesting a two year transition of all 010 and 090 global services to a 000 global. CMS finalized this proposal in within the final 2015 MPFS rule. They justify this decision based on their belief that in the context of the misvalued code initiative, it is critical for the RVUs used to develop PFS payment rates reflect the most accurate resource costs associated with PFS services. CMS does not believe that maintaining the post-operative 10-and 90-day global periods is compatible with their 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, they 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. They 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, they feel 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.

CMS plans 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. CMS believes 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 (CMS is clear in the rule they do not believe there should not be increased PE for surgical specialties when post-operative visits are provided, as compared to the PE included in a standard E/M visit);
• Facilitate availability of more accurate data for new payment models and quality research.

As they transition these codes, CMS acknowledges they will 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. **CMS also states they intend to monitor any changes in the utilization of E/M visits following its implementation and seeking comment on potential payment policies that will mitigate such a change in behavior.**

CMS urges stakeholders to engage with them to determine the best method of operationalizing this change and puts forward several suggested approaches for consideration, including:

- Surveying high volume surgical codes as standalone procedures via the normal RUC process;
- Using a reverse building block approach to back visits out of the global codes to obtain a base procedure RVU and then using the current potentially misvalued code process to identify and value the small number of codes that represent the majority of the volume of services that are currently reported with codes with post-operative periods. 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.

CMS states that prior to implementing these changes they intend to gather objective data on the number of E/M and other services furnished during the current post-operative periods and use that data to inform both the valuation of particular services and the budget neutrality adjustments required to implement this proposal. They note that collecting information through claims submission may be the best approach and they will propose such a collection through future rulemaking. They also ask for alternative suggestions to gather this information.