[CMS-1654-P] - Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model

Collecting Data on Resources Used in Furnishing Global Services

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Comment Deadline

CMS is accepting comments on the proposal as part of the 2017 Physician Fee Schedule proposed rule until September 6, 2016 at Regulations.gov. CMS will issue the final rule by November 1, 2016.

Summary of Proposal

Many surgical spine procedures are valued and paid for as part of global packages that include the procedure and the services typically furnished in the periods immediately before and after the procedure. Codes with 90-day global periods include any services provided to the patient one day prior to procedure through 90-days post-op. The global package includes the following services related to the procedure:

- Pre-Operative Visits
- Intra-Operative Services
- Complications Following Surgery
- Post-Operative Visits
- Post-Surgical Pain Management
- Supplies
- Miscellaneous Services

Citing concerns with lack of data to verify and update the values of codes with global packages, the Centers for Medicare and Medicaid Services (CMS) finalized a policy to transform all 10- and 90-day global codes to 0-day global codes beginning in 2018. Under this policy, CMS would have valued the surgery or procedure to include all services furnished on the day of surgery and paid separately for visits and services furnished after the day of the procedure. Subsequently, Congress enacted Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 prohibiting CMS from implementing this policy and requiring the agency to gather data on visits in the post-surgical period that could be used to accurately value these services.

In this year's proposed Physician Fee Schedule rule, CMS is proposing a three-pronged data collection strategy to gather information on the frequency of, and inputs involved in furnishing global services, including the procedure, pre-operative visits, post-operative visits, and other services for which payment is included in the global surgical payment for 4,200 codes with a 10- or 90-day global period. Specifically, the data collection effort would include:

1. Comprehensive claims-based reporting about the number and level of pre- and post- operative visits furnished for 10- and 90-day global services;

2. A survey of a representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time, such as two weeks; and
3. A more in-depth study, including direct observation of the pre- and post-operative care delivered in a small number of sites, including some ACOs.

In order to collect claims-based data, CMS is proposing to require **ALL** physicians who furnish procedures with 10-day and 90-day global periods to report the number and level of pre- and post-operative visits using a new set of G-codes that distinguish between the setting of care (hospital, office, email/telephone) and whether the services are furnished by a physician or by their clinical staff. Physicians would be required to report the following G-codes for every 10 minutes dedicated to a patient before and after a procedure or surgery:

Inpatient	GXXX1	Inpatient visit, typical, per 10 minutes, included in surgical package
	GXXX2	Inpatient visit, complex, per 10 minutes, included in surgical package
	GXXX3	Inpatient visit, critical illness, per 10 minutes, included in surgical package
Office or Other Outpatient	GXXX4	Office or other outpatient visit, clinical staff, per 10 minutes, included in surgical package
	GXXX5	Office or other outpatient visit, typical, per 10 minutes, included in surgical package
	GXXX6	Office or other outpatient visit, complex, per 10 minutes, included in surgical package
Via Phone or Internet	GXXX7	Patient interactions via electronic means by physician/NPP, per 10 minutes, included in surgical package
	GXXX8	Patient interactions via electronic means by clinical staff, per 10 minutes, included in surgical package

(Note: CMS is proposing these codes be used for reporting on claims the services actually furnished but not paid separately because they are part of global packages. No separate payment would be made for these codes. Also, CMS states they are not proposing to withhold payment for non-compliance at this time, but may do so in the future.)

Problems with CMS' Proposal

- Rather than using well-known, established E/M codes, CMS is creating new, poorly constructed G-codes to report patient visits in 10-minute increments.
- It is unclear how CMS will use the data collected from the G-codes and translate them into the existing E/M structure.
- The statute requires CMS to gather data from a representative sample, not the entire population of physicians who furnish procedures with 10- and 90-day global periods.
- It is not feasible to require the collection of time per patient, at the minute level, for every task that a physician and his/her clinical staff perform on a daily basis.
- The data reported will be unreliable for reasons including:
    - It is likely that only large, urban, technologically rich practices will have the means to report data leaving the population of small and rural practices unrepresented.
    - The process is biased towards underreporting of time as any patient encounter not reported by a physician and his/her staff (i.e. due to system failure, lack of time for reporting, forgetting encounters, etc.) will undermine the accuracy of the data.

- The data will not capture the full range of services provided to patients and families by the physician and his/her staff during the post-operative period.
- The burden of reporting falls to the physician and his/her staff, which represents another unfunded regulatory mandate at a time when practices are devoting considerable time and resources to implement other major changes required by MACRA.

Opportunity to Provide Feedback to CMS

- CMS is accepting public comments on the proposal as part of the 2017 Physician Fee Schedule proposed rule until September 6, 2016 at the following link: https://www.regulations.gov/document?D=CMS-2016-0116-0006 (click on the blue "Comment Now!" button in the top right corner)