ascertaining whether or not there are nonfacility direct PE inputs that are not included in the direct PE inputs that are typical supply costs for these services.

(4) Mammography—CPT Codes 77055, 77056, and 77057, and HCPCS Codes G0202, G0204, and G0206

Medicare currently pays for mammography services through both CPT codes, (77055 (mammography; unilateral), 77056 (mammography; bilateral) and 77057 (screening mammography, bilateral (2-view film study of each breast)) and HCPCS G-codes, (G0202 (screening mammography, producing direct digital image, bilateral, all views), G0204 (diagnostic mammography, producing direct digital image, bilateral, all views), and G0206 (diagnostic mammography, producing direct digital image, unilateral, all views)). The CPT codes were designed to be used for mammography regardless of whether film or digital technology is used. However, for Medicare purposes, the HCPCS G-codes were created to be used for digital technology in response to special payment rules for digital mammography included in the Medicare Benefit Improvements and Protection Act of 2000.

As discussed in section II.A., the RUC recommended that CMS update the direct PE inputs for all imaging codes to reflect the migration from film-to-digital storage technologies since digital storage is now the typically used in imaging.

Our data confirms that the overwhelming majority of all mammography is digital. As a result, we are proposing that the CPT codes 77055, 77056 and 77057 be used for reporting mammography to Medicare regardless of whether film or digital technology is used, and to delete the HCPCS G-codes G0202, G0204, and G0206. We are proposing, for CY 2015, to value the CPT codes using the values established for the digital mammography G-codes since digital technology is now the typical service. (See section II.A. of this proposed rule for more discussion of this proposal.) In addition, since the G-codes values that we propose to use for the CPT codes for CY 2015 have not been reviewed since they were created in CY 2002, we are proposing to include CPT codes 77055, 77056, and 77057 on the list of potentially misvalued codes.

(5) Abdominal Aortic Aneurysm Ultrasound Screening—G0389

When Medicare began paying for abdominal aortic aneurysm (AAA) ultrasound screening in CY 2007, we created HCPCS code G0389 (Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening), and set the RVUs at the same level as CPT code 76775 (Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), B-scan and/or real time with image documentation; limited). We noted in the CY 2007 final rule with comment period that CPT code 76775 was used to report the service when furnished as a diagnostic test and that we believed the service reflected by G0389 used equivalent resources and work intensity to those contained in CPT code 76775 (71 FR 69664 through 69665).

In the CY 2014 proposed rule, based on a RUC recommendation, we proposed to replace the ultrasound room included as a direct PE input for CPT code 76775 with a portable ultrasound unit. Since all the RVUs (including the PE RVUs) for G0389 were crosswalked from CPT code 76775, the proposed PE RVUs for G0389 in the CY 2014 proposed rule were reduced significantly as a result of this change to the direct PE inputs for 76775. However, we did not discuss the applicability of this change to G0389 in the proposed rule's preamble and did not receive any comments on G0389 in response to the proposed rule. We finalized the change to CPT code 76775 in the CY 2014 final rule with comment period and the corresponding PE RVUs for G0389 were also reduced.

Subsequent to the publication of the CY 2014 final rule, a stakeholder suggested that the reduction in the RVUs for G0389 did not accurately reflect the resources involved in furnishing the service and asked that CMS consider using an alternative crosswalk. Specifically, the stakeholder stated that the type of equipment typically used in furnishing G0389 is different than that used for CPT code 76775, the time involved in furnishing G0389 is greater than that of CPT code 76775, and the specialty that typically furnishes G0389 is different than the one that typically furnishes CPT code 76775. The stakeholder suggested an alternative crosswalk of CPT code 76705 (Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)).

After considering the issue, we are proposing G0389 as a potentially misvalued code and seeking recommendations regarding the appropriate inputs that should be used to develop RVUs for this code. We have not reviewed the inputs used to develop RVUs for this code since it was established in CY 2007 and the RVUs were directly crosswalked from 76705. Based on the issues raised by stakeholders, we believe that we should value this code through our standard methodologies, including the full PE RVU methodology. In order to do so, we are proposing to include this code on our list of proposed potentially misvalued codes and seek input from the public and other stakeholders, including the RUC, regarding the appropriate work RVU, time, and direct PE inputs that reflect the typical resources involved in furnishing the service.

Until we receive the information needed to revalue this service, we are proposing to maintain the work RVU for this code and revert to the same PE RVUs we used for CY 2013, adjusted for budget neutrality. We are proposing MP RVUs based on the five-year review update process as described in section II.C of this proposed rule. We believe this valuation will ameliorate the effect of the CY 2014 reduction in G0389 that resulted from reflection of the change in RVUs for the crosswalked code while we assess the valuation of this code through our usual methodologies. The proposed PE RVUs are contained in Addendum B available on the CMS Web site under downloads for the CY 2015 PFS proposed rule at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

(6) Prostate Biopsy Codes—HCPCS Codes G0416, G0417, G0418, and G0419

For CY 2014, we modified the code descriptors of G0416 through G0419 so that these codes could be used for any method of prostate needle biopsy services, rather than only for prostate saturation biopsies. The CY 2014 descriptions are:

- G0416 (Surgical pathology, gross and microscopic examination for prostate needle biopsies, any method; 10–20 specimens).
- G0417 (Surgical pathology, gross and microscopic examination for prostate needle biopsies, any method; 21–40 specimens).
- G0418 (Surgical pathology, gross and microscopic examination for prostate needle biopsies, any method; 41–60 specimens).
- G0419 (Surgical pathology, gross and microscopic examination for prostate needle biopsies, any method; greater than 60 specimens).

Subsequently, we have discussed prostate biopsies with stakeholders, and reviewed medical literature and Medicare claims data in considering how best to code and value prostate biopsy pathology services. In considering these discussions and our review, we have become aware that the

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