

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 414

[CMS-1476-P]

RIN 0938-AL96

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would refine the resource-based practice expense relative value units (RVUs) and make other changes to Medicare Part B payment policy. The policy changes concern: Medicare Economic Index, practice expense for professional component services, definition of diabetes for diabetes self-management training, supplemental survey data for practice expense, geographic practice cost indices, and several coding issues.

We are proposing these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We solicit comments on these proposed policy changes.

We also discuss the non-physician work-pool, the 5-year review of anesthesia services, and outpatient therapy services performed "incident to" physician services.

DATES: We will consider comments if we receive them at the address, provided below, no later than 5 p.m. on October 7, 2003.

ADDRESSES: In commenting, please refer to file code CMS-1476-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission or e-mail. Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS-1476-P, P.O. Box 8013, Baltimore, MD 21244-8013. Please allow sufficient time for us to receive mailed comments on time in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses: Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5-14-03, 7500 Security Boulevard, Baltimore, MD 21244-1850.

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Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Gail Addis (410) 786-4522 (for issues related to repricing of supplies for practice expense inputs.)

Pam West (410) 786-2302 (for issues related to Practice Expense Advisory Committee (PEAC) recommendations.)

Jim Menas (410) 786-4507 (for issues related to anesthesia.)

Rick Ensor (410) 786-5617 (for issues related to Geographic Cost Price Index (GPCI)).

Mary Stojak (410) 786-6939 (for issues related to the definition of diabetes for diabetes self-management training (DSMT)).

Shannon Martin (410) 786-7939 (for issues related to rebasing of the Medicare Economic Index (MEI)).

Dorothy Shannon (410) 786-3396 (for issues related to the "Incident To" Therapy Discussion).

Diane Milstead (410) 786-3355, Latesha Walker (410) 786-1101, or Gaysha Brooks (410) 786-3355 (for all other issues).

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are processed, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786-7197.

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1. Go to the CMS homepage (<http://www.cms.hhs.gov>).
2. Place your cursor over the word "Professionals" in the blue area near the top of the page. Select "physicians" from the drop-down menu.
3. Under "Policies/Regulations" select "Physician Fee Schedule."

Or, you can go directly to the Physician Fee Schedule page by typing the following: <http://www.cms.hhs.gov/physicians/pfs>.

To assist readers in referencing sections contained in this preamble, we are providing the following table of contents. Some of the issues discussed in this preamble affect the payment policies but do not require changes to the regulations in the Code of Federal Regulations. Information on the regulation's impact appears throughout the preamble and is not exclusively in section VII.

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In addition, because of the many organizations and terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

AMA American Medical Association
 BBA Balanced Budget Act of 1997
 BBRA Balanced Budget Refinement Act of 1999
 CF Conversion factor
 CFR Code of Federal Regulations
 CMS Centers for Medicare & Medicaid Services
 CNS Clinical Nurse Specialist
 CPT [Physicians'] Current Procedural Terminology [4th Edition, 2002, copyrighted by the American Medical Association]
 CPEP Clinical Practice Expert Panel
 CRNA Certified Registered Nurse Anesthetist
 E/M Evaluation and management
 FMR Fair market rental
 GAF Geographic adjustment factor
 GPCI Geographic practice cost index
 HCPCS Healthcare Common Procedure Coding System
 HHA Home health agency
 HHS [Department of] Health and Human Services
 IDTFs Independent Diagnostic Testing Facilities
 MCM Medicare Carrier Manual
 MedPAC Medicare Payment Advisory Commission
 MEI Medicare Economic Index
 MGMA Medical Group Management Association
 MPFS Medicare Physician Fee Schedule
 MSA Metropolitan Statistical Area
 NAMCS National Ambulatory Medical Care Survey
 PC Professional component
 PEAC Practice Expense Advisory Committee
 PPS Prospective payment system
 RUC [AMA's Specialty Society] Relative [Value] Update Committee
 RVU Relative value unit
 SGR Sustainable growth rate
 SMS [AMA's] Socioeconomic Monitoring System
 SNF Skilled Nursing Facility

TC Technical component

I. Background

A. Legislative History

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), "Payment for Physicians' Services." This section provides for three major elements: (1) A fee schedule for the payment of physicians' services; (2) limits on the amounts that nonparticipating physicians can charge beneficiaries; and (3) a sustainable growth rate for the rates of increase in Medicare expenditures for physicians' services. The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) based on the resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense, and malpractice expense. Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs may not cause total physician fee schedule payments to differ by more than \$20 million from what they would have been had the adjustments not been made. If adjustments to RVUs cause expenditures to change by more than \$20 million, we must make adjustments to ensure that they do not increase or decrease by more than \$20 million.

B. Published Changes to the Fee Schedule

In the July 2000 proposed rule, (65 FR 44177), we listed all of the final rules published through November 1999. In the August 2001 proposed rule (66 FR 40372) we discussed the November 2000 final rule relating to the updates to the RVUs and revisions to payment policies under the physician fee schedule.

In the November 2001 final rule with comment period (66 FR 55246), we made revisions to resource-based practice expense RVUs; services and supplies incident to a physician's professional service; anesthesia base unit variations; recognition of CPT tracking codes; and nurse practitioners, physician assistants, and clinical nurse specialists performing screening sigmoidoscopies. We also addressed comments received on the June 8, 2001 proposed notice (66 FR 31028) for the 5-year review of work RVUs and finalized these work RVUs. In addition, we acknowledged comments received in response to a discussion of modifier-62, which is used to report the work of co-surgeons. The November 2001 final rule also updated the list of services that are subject to the physician self-referral

prohibitions in order to reflect CPT and Healthcare Common Procedure Coding System (HCPCS) code changes that were effective January 1, 2002. All these revisions ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. This final rule also conformed our regulations to reflect statutory provisions of Medicare, Medicaid, and State Child Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554) (BIPA) concerning: The mammography screening benefit; biennial screening pelvic examinations for certain beneficiaries; expanded coverage for screening colonoscopies to all beneficiaries; provided for annual glaucoma screenings for high-risk beneficiaries; established coverage for medical nutrition therapy services for certain beneficiaries; expanded payment for telehealth services; required certain Indian Health Service providers to be paid for some services under the physician fee schedule; and revised the payment for certain physician pathology services.

In the December 31, 2002 final rule with comment period (67 FR 79966), we refined resource-based practice expense RVUs and made other changes to Medicare Part B policy. These included: The pricing of the technical component for positron emission tomography (PET) scans, Medicare qualifications for clinical nurse specialists, a process to add or delete services to the definition of telehealth, the definition for ZZZ global periods, global period for surface radiation, and application of endoscopic reduction rules for certain codes. In addition, this rule: Updated the codes subject to physician self-referral prohibitions, expanded the definition of a screening fecal-occult blood test, and modified our regulations to expand coverage for additional colorectal cancer screening tests through our national coverage determination process. We also made revisions to the sustainable growth rate, the anesthesia conversion factor (CF), and the work values for some gastroenterologic services. We finalized the CY 2002 interim RVUs and assigned interim RVUs for new and revised procedure codes for calendar year CY 2003, clarified the enrollment of therapists in private practice and the policy regarding services and supplies incident to a physician's professional services, and made technical changes to the definition of outpatient rehabilitation services.

This final rule also revised the regulations at 42 CFR 485.618 to allow registered nurses (RNs) to provide

emergency care in certain critical access hospitals (CAHs) in frontier areas (an area with fewer than six residents per square mile) or remote locations (locations designated in a State's rural health plan that we have approved).

As required by statute this final rule also announced that the physician fee schedule update for CY 2003 was -4.4 percent, the initial estimate of the sustainable growth rate (SGR) for CY 2003 was 7.6 percent, and the CF for CY 2003 was \$34.5920, effective March 1, 2003. However, on February 28, 2003 (68 FR 9567), after enactment of the Consolidated Appropriations Resolution of 2003 (Pub. L. 108-7), we published a final rule that revised the estimates used to establish the SGRs for fiscal years 1998 and 1999 and announced a 1.6 percent increase in the CY 2003 physician fee schedule CF for March 1 to December 31, 2003. The CF for March 1 to December 31, 2003 is \$36.7856. The anesthesia CF for this period is \$17.05. All other provisions of the December 31, 2002 final rule were unchanged by the rule published February 28, 2003.

II. Provisions of the Proposed Rule

This proposed rule would affect the regulations set forth at Part 410, Supplementary medical insurance (SMI) benefits and part 414, Payment for Part B and other health services.

A. Resource-Based Practice Expense Relative Value Units

1. Resource-Based Practice Expense Legislation

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103-432), enacted on October 31, 1994, required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service beginning in 1998. In developing the methodology, we were to consider the staff, equipment, and supplies used in providing medical and surgical services in various settings. The legislation specifically required that, in implementing the new system of practice expense RVUs, we apply the same budget-neutrality provisions that we apply to other adjustments under the physician fee schedule.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33), enacted on August 5, 1997, amended section 1848(c)(2)(ii) of the Act and delayed the effective date of the resource-based practice expense RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period

from charge-based practice expense RVUs to resource-based RVUs.

Further legislation affecting resource-based practice expense RVUs was included in the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113) enacted on November 29, 1999. Section 212 of the BBRA amended section 1848(c)(2)(ii) of the Act by directing us to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations. These data would supplement the data we normally collect in determining the practice expense component of the physician fee schedule for payments in CY 2001 and CY 2002. (In the 1999 final rule (64 FR 59380), we extended, for an additional 2 years, the period during which we would accept supplementary data.)

2. Current Methodology for Computing the Practice Expense Relative Value Unit System

Effective with services furnished on or after January 1, 1999, we established a new methodology for computing resource-based practice expense RVUs that used the two significant sources of actual practice expense data we have available—the Clinical Practice Expert Panel (CPEP) data and the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) data. The methodology was based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs for physicians' services across specialties. The methodology allocated these aggregate specialty practice costs to specific procedures and, thus, can be seen as a "top-down" approach.

a. Major Steps

A brief discussion of the major steps involved in the determination of the practice expense RVUs follows. (Please see the November 1, 2001 final rule (66 FR 55249) for a more detailed explanation of the top-down methodology.)

- *Step 1*—Determine the specialty specific practice expense per hour of physician direct patient care. We used the AMA's SMS survey of actual aggregate cost data by specialty to determine the practice expenses per hour for each specialty. We calculated the practice expenses per hour for the specialty by dividing the aggregate practice expenses for the specialty by

the total number of hours spent in patient care activities.

- *Step 2*—Create a specialty specific practice expense pool of practice expense costs for treating Medicare patients. To calculate the total number of hours spent treating Medicare patients for each specialty, we used the physician time assigned to each procedure code and the Medicare utilization data. We then calculated the specialty specific practice expense pools by multiplying the specialty practice expenses per hour by the total physician hours.

- *Step 3*—Allocate the specialty specific practice expense pool to the specific services performed by each specialty. For each specialty, we divided the practice expense pool into two groups based on whether direct or indirect costs were involved and used a different allocation basis for each group.

- (i) Direct costs—For direct costs (which include clinical labor, medical supplies, and medical equipment), we used the procedure specific CPEP data on the staff time, supplies, and equipment as the allocation basis.

- (ii) Indirect costs—To allocate the cost pools for indirect costs, including administrative labor, office expenses, and all other expenses, we used the total direct costs combined with the physician fee schedule work RVUs. We converted the work RVUs to dollars using the Medicare CF (expressed in 1995 dollars for consistency with the SMS survey years).

- *Step 4*—For procedures performed by more than one specialty, the final procedure code allocation was a weighted average of allocations for the specialties that perform the procedure, with the weights being the frequency with which each specialty performs the procedure on Medicare patients.

b. Other Methodological Issues

(i) Non-Physician Work Pool

For services with physician work RVUs equal to zero (including the technical components of radiology services and other diagnostic tests), we created a separate practice expense pool using the average clinical staff time from the CPEP data and the "all physicians" practice expense per hour.

We then used the adjusted 1998 practice expense RVUs to allocate this pool to each service. We have removed services from the non-physician work pool if the requesting specialty predominates utilization of the service. Also, for all radiology services that are assigned physician work RVUs, we used the adjusted 1998 practice expense RVUs for radiology services as an

interim measure to allocate the direct practice expense cost pool for radiology.

(ii) Crosswalks for Specialties Without Practice Expense Survey Data

Since many specialties identified in our claims data did not correspond exactly to the specialties included in the SMS survey data, it was necessary to crosswalk these specialties to the most appropriate SMS specialty.

(iii) Physical Therapy Services

Because we believe that most physical therapy services furnished in physicians' offices are performed by physical therapists, we crosswalked all utilization for therapy services in the CPT 97000 series to the physical and occupational therapy practice expense pool.

3. Practice Expense Proposals for Calendar Year 2004

a. Non-Physician Work Pool

The non-physician work pool was created as an interim measure until we could further analyze the effect of the top-down methodology on the Medicare payment for services that do not have physician work RVUs (see the November 1998 final rule (63 FR 58841)).

In the June 28, 2002 proposed rule (67 FR 43849), we discussed alternatives that we have considered to address the non-physician work pool issue, including ideas raised by the Lewin Group as well as recommendations in a 2001 GAO report. While we have not reached a final resolution on how to best address this issue, we are continuing to study the alternatives that are available. We also believe that our proposal extending the deadline for the submission of supplemental survey data (see following discussion) will provide an opportunity for specialties whose services are affected by the non-physician work pool to submit practice expense data that can be used for determining practice expense RVUs under the physician fee schedule. Any modifications to the non-physician work pool would be published in proposed rulemaking.

b. Supplemental Practice Expense Survey Data

As required by the BBRA, we established criteria to evaluate data collected by organizations to supplement the data normally used in determining the practice expense component of the physician fee schedule. Due to the time constraints imposed by the statute for publication of the physician fee schedule final rule, we have required supplementary survey

data to be submitted by August 1 to be considered for computing practice expense RVUs for the following year. We are proposing to change the required submission date to March 1. This would allow us to publish our decisions regarding survey data in the proposed rule and would provide an opportunity for public comment on survey results.

To continue to ensure the maximum opportunity for specialties to submit supplementary practice expense data, we are again proposing to extend for an additional 2 years the period for accepting survey data that meets the criteria set forth in the November 2000 final rule (as modified in the December 31, 2002 final rule). The deadline for submission of the supplemental data to be considered in CY 2005 and CY 2006 are March 1, 2004 and March 1, 2005, respectively.

In the December 31, 2002 final rule (67 FR 79979), we responded to comments expressing concern about the impact of making the technical component the difference between the global and professional component practice expense RVUs for services that are not affected by the non-physician work pool calculations. We agreed to a one-year moratorium on implementation of the proposed change for pathology services paid under the physician fee schedule to allow for a supplemental survey of independent laboratories. Consistent with the change to making the survey deadline March 1, we are considering whether to extend the moratorium by one additional year. By extending the moratorium, we can show the impact of the independent laboratory survey in the 2004 proposed rule and allow public comment on its results prior to making changes to the practice expense RVUs on January 1, 2005. We welcome public comment on whether we should adopt the proposed change for 2004 in this year's final rule or extend the moratorium by 1 year.

c. Oncology Survey Data

In the December 31, 2002 final rule (67 FR 79973), we indicated that the American Society of Clinical Oncology (ASCO) submitted a supplemental practice expense survey. Our contractor, the Lewin Group, raised specific concerns to us about the survey results. Consequently, we did not incorporate the survey into the practice expense methodology but indicated that we would further examine its results with the Lewin Group and confer with ASCO about our concerns. We have discussed the oncology survey together with the Lewin Group and ASCO. These discussions were useful in providing us with more information upon which to

make a final decision regarding incorporation of the oncology survey into the practice expense methodology. We expect to make our decision known in a subsequent proposed rule that will address Medicare payment for drugs currently paid based on 95 percent of the average wholesale price.

d. Practice Expense for a Professional Component Service

Since the inception of the resource-based practice expense methodology, we have assigned all staff equipment and supply costs for services with professional and technical components (PC and TC) to the technical portion of the service. We have done this because we believe that generally all of these direct cost inputs are associated with obtaining the diagnostic information and there would be no direct costs associated with the physician interpretation. However, we now believe that there may be limited exceptions where it is appropriate to assign direct inputs to a PC service. For instance, the Practice Expense Advisory Committee (PEAC) recommended that we include clinical staff time in certain codes that have both a PC and TC component for activities such as scheduling the procedure and educating the patient when the procedure is done in the facility setting. We accepted these recommendations but, because the practice expense methodology currently does not assign direct inputs to PC services and the TC is not paid in the facility setting, these procedures were not credited with the recommended practice expense inputs.

We propose to modify the practice expense methodology to allow direct inputs to be added to PC services when these inputs are clearly associated with the professional service, including when the PEAC makes such recommendations. We are proposing to add the PEAC recommended staff times to the PC of the following cardiac services: CPT codes 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533 and 93624. The practice expense RVUs for these codes will increase slightly from this change resulting in minor reductions in practice expense RVUs for some other services performed by cardiologists. There will be no impact on the practice expense RVUs for any other specialty.

e. Utilization Data

We use Medicare utilization data in the development of specialty-specific practice expense RVUs that are then weight averaged to determine a single practice expense RVU per code. Prior to

2003, we used the most recent complete year of utilization data to determine the practice expense RVUs. For instance, we determined the 2001 practice expense RVUs using Medicare utilization data from 1999 for most procedure codes. However, if a procedure code was new in 2000, we did not have any 1999 utilization data to determine its 2001 practice expense RVU and could not use specialty-specific data until 2000 utilization data was available to us. In some cases, the new code was clearly related to an older code or codes and we were able to use an estimation of the probable specialty utilization for 2001 until actual specialty-specific utilization was available for 2002. Where we were not able to determine the probable specialty-specific utilization we assigned the "all physician" average practice expenses to the service until we obtained specialty-specific utilization. Thus, in this case, we used the "all physician average" to determine the code's 2001 practice expense RVU and specialty-specific utilization to determine the 2002 practice expense RVU.

In the December 31, 2002 final rule (67 FR 79982), we adopted a policy of using the 1997 through 2000 Medicare utilization in the practice expense methodology. For new codes created since 2000, there are no Medicare utilization data in the 1997 through 2000 period upon which to determine specialty-specific practice expenses. We are proposing to follow a similar practice to the one described above and use specialty-specific Medicare utilization data for codes created after 2000 at the first opportunity they become available to us. Therefore, we are proposing to use 1997 through 2000 Medicare utilization data for all codes that were in existence at that time. If a code did not exist during the 1997 through 2000 period, we propose using the first available utilization data for the code in order to develop the practice expense RVU. Since we will not have any utilization data at the time we first establish practice expense RVUs for a new code, we propose that we continue, whenever possible, to make an assumption about the specialty that will likely provide the service or to use the "all physician" average when we do not have sufficient information to assign any given specialty. We will make available on the CMS web site (<http://cms.hhs.gov>) files containing the data that we will use in determining the proposed rule practice expense RVUs. We propose in each year's proposed rule to substitute actual for estimated utilization once the data become

available. For instance, in this proposed rule, we will substitute actual 2002 utilization data for estimated 2002 utilization data to determine the 2004 practice expense RVUs for codes that were new in 2002. Practice expense RVUs may change as we make updates to the utilization data that we use in the practice expense methodology. We encourage the AMA's Specialty Society Relative Value Update Committee (RUC) and other interested parties to provide information on the specialties that will likely perform a new service to minimize the potential changes to the practice expense RVUs that will occur when we substitute actual for estimated utilization.

For the proposed rule, the utilization data from the prior year are 96 percent complete. In the past, we used 100 percent complete data from a prior year in the proposed rule (for example, we used 2000 utilization data to simulate impacts for the June 28, 2002 proposed rule) and did not use the preceding year's utilization data until the final rule (for example, we used 2001 utilization data to simulate impacts for the December 31, 2002 final rule). Beginning with this year's proposed rule, we are using the prior year's utilization data for developing practice expense RVUs and simulating impacts. Because the utilization file that we are using for the proposed rule is only 96 percent complete, there may be minor changes to the payment impacts and practice expense RVUs between the proposed rule and the final rule for which we will use 100 percent complete data from the prior year.

f. Practice Expense Advisory Committee (PEAC)

Recommendations on CPEP Inputs for 2004

The PEAC, a subcommittee of the RUC, has, since 1999, been providing us with recommendations for refining the direct practice expense inputs (clinical staff, supplies, and equipment) for existing CPT codes. In the past, our actions on these PEAC recommendations have been incorporated into the physician fee schedule final rule and have been used as interim values for services provided in the following calendar year. We have accepted comments on these refinements and addressed them in rulemaking the following year. This year we are including the PEAC recommendations in the proposed rule, which will enable specialty groups to assess the impact of these changes on their services and make comments on

the recommendations before the final rule.

These PEAC recommendations are the result of meetings held in September of 2002 and January 2003 and account for approximately 772 codes from many specialties. (A list of these codes can be found in Addendum C.) The PEAC has also submitted recommendations on the refinements to the clinical staff time for all 90-day global services (accounting for a further 3,604 CPT codes).

This massive refinement was possible because the PEAC adopted a standardized approach to the refinement of the clinical staff times for 90-day global codes. The PEAC has recommended that the following standard clinical staff times be applied to all 90-day codes, except for those in which the specialty argued for an exception to the standard:

- Pre-service time—35 minutes of pre-service clinical staff time in the office and 60 minutes for services performed in the facility setting;
- Discharge day management time—6 minutes of clinical staff time if the procedure is performed predominantly in the outpatient facility setting and 12 minutes if performed predominantly in the inpatient setting. (This standard is also recommended for all of the 10-day global procedures); and
- Post-service office visit time—equal to the clinical staff times associated with the evaluation and management visit codes assigned to each service.

Several specialties, including the neurosurgeons/spine surgeons, thoracic surgeons and colorectal surgeons requested and received increased pre-service times for some of their services. There were also a few services that are usually performed on an emergent basis when the pre-service time was reduced or omitted altogether. We believe that the standards recommended by the PEAC are appropriate and that the exceptions to these standards are also reasonable. Therefore, we are proposing to use the PEAC's recommendations for the clinical staff time for these global codes.

In addition, the PEAC convened a workgroup to make recommendations on the refinement of all the 116 remaining evaluation and management codes. These are important achievements that have significantly advanced the pace of the refinement process. A total of 5358 codes have been refined; these codes represent 87 percent of physician fee schedule dollars. We greatly appreciate the dedication and hard work of the specialty societies and the AMA that are helping to ensure that this refinement process is successful.

We have reviewed the submitted PEAC recommendations and propose to accept them. The complete PEAC recommendations and the revised CPEP database can be found on our web site. (See the Supplementary Information section of this proposed rule for directions on accessing our web site.)

g. Repricing of Clinical Practice Expense Inputs—Supplies

We use the practice expense inputs (the clinical staff, supplies, and equipment assigned to each procedure) to allocate the specialty-specific practice expense cost pools to the procedures performed by each specialty. The costs of the original inputs assigned by the CPEP were determined by our contractor, Abt Associates, based primarily on 1994 and 1995 pricing data from supply catalogs. In addition, for many items on the equipment and supply list, the associated costs were based on the recommendations of a CPEP panel member, rather than on actual catalog prices. Subsequent to the CPEP panels, equipment and supply items have also been added to the CPEP data, with the costs of the inputs provided by the relevant specialty society.

In the August 2, 2001 proposed rule (66 FR 40378), we proposed updates and revisions to the clinical staff salary data which were finalized in the final rule published November 1, 2001 (66 FR 55255). In that final rule, we also indicated that in future rulemaking we would be proposing updates to the supply and equipment inputs that are used in the CPEP database. We, therefore, contracted with a consultant to assist us in obtaining the current price for each supply item in our CPEP database. The consultant has been able to determine the current prices for most of the supply inputs and has submitted documentation for the proposed new pricing from vendor catalogs or websites. Whenever possible, multiple sources were obtained for frequently used supplies so that a typical price could be determined.

In addition, we asked the consultant to help identify and clarify those supplies for which the original descriptions in the CPEP database are too general to price (for example “laser” or “antigen”) or are otherwise unidentifiable. Our consultant worked closely with the specialty societies to ensure that accurate information was obtained in identifying as many of these supplies as possible.

Addendum D contains the proposed new unit prices for supply items when current pricing was obtained, as well as new descriptions when needed. A more detailed spreadsheet can be found on our Web site, (<http://www.cms.hhs.gov/physicians/pfs>), that contains additional information regarding the sources used to price each item.

There are items that have either not yet been identified or for which pricing information has not yet been found. These supply items are included in Table 1 below. In this table we have identified the supply code (if assigned), the existing item description, unit and price, the procedures or specialties associated with the item, as well as the proposed new description and standardized unit of use. We have also identified items for deletion from the database. We are requesting that commenters, particularly the relevant specialty groups, provide us with the needed pricing information with appropriate documentation. Whenever possible, multiple sources of documentation should be provided so that a typical price can be determined. If we are not able to obtain any verified pricing information for an item, we may eliminate it from the database.

BILLING CODE 4120-01-P

Table 1
Items Needing Specialty Input for Pricing and Proposed Deletions

2003 PE supply code	2003 PE Supply description	2003 PE Unit	2003 PE unit price	Primary specialties associated with supply item	*CPT code(s) associated with supply item	Status of supply item
72006	acetylcholine 10%	1 gram	0.40	nurse practitioner, neurology	95923	See Note C. Need patient-use item, not R&D item.
	aerochamber	1 item		cardiology, internal medicine	93720	Item may be deleted. May not be typical and may be separately billable.
	albuterol	1 ampule		family practice, internal medicine	94640	See Note B.
	anthralin ointment	1 g	2.75	dermatology	96910, 96912, 96913	See Note C.
	aphasia assessment - forms average	1 item	0.95	psychiatry, neurology	96105	See Note C.
	balloon, achalasia	1 item	255.00	general surgery, colon and rectal surgery	45905, 45910	See Note C. (Codes utilizing this item being reviewed by CPT)
	blood dress package	1 item		neurosurgery	61608	Item may be deleted. Gowning items listed separately.
	broach kit	1 item		podiatry, orthopaedic surgery	28293	See Note A.
	cable for EMG needle electrode	1 item	1.20	neurology, PM&R	95860-95870	See Note A.
	Centimeter ruler	1 each	2.39	radiation oncology, dermatology	77401-77413	See Note A.
20011	cephalosporin	1 gm		podiatry, orthopaedic surgery	28293	See Note B.
	Chordae Villae Sampling Kit	1 item		obstetrics, gynecology	59015	Item may be deleted. Duplicated item with catheter-stylet kit.
	collagen kit	1 each	1383.00	urology	52327	Need kit contents. Collagen sold as individual syringe. No commercial kit available.
	Communication Book/Treatment notebooks cottonoids	1 each		otolaryngology, audiology	92507, 92508	See Note C.
93111	CPAP nasal pillow	1 each		pulmonary medicine	69105, 92511, multiple rhinology codes	See Note C.
	Cysto-catheter kit	1 item	9.04	urology, general practice	95811	Item may be deleted. Disposable CPAP face mask also included in code 95811. Nasal pillows used with reusable mask.
	detection kit	1 slide	8.50	pathology, neurology	51005	Need kit contents and source/pricing information. (Codes utilizing this item being reviewed by CPT.)
	developmental testing - forms average	1 item	2.64	clinical psychologist, multiple other specialties	88355-88358	See Note C. (Codes utilizing this item being reviewed by CPT)
	eartip insert with sound tube	1 item		otolaryngology, audiology	96110, 96111	See Note C. (Original item price estimated by CPEP member.)
	EEG electrode, gold DIN	1 item	0.07	neurology	92552-92557	See Note C.
	electrode, ring	1 item	475.00	obstetrics, gynecology, urology	92585, 95812, 95813, 95816, 95819, 95822, 95925, 95926, 95930	See Note A.
	electrodes, pick-up, black tin, 9mm	1 item	0.42	podiatry, neurology	51792	See Note A.
	electrodes, pick-up, red tin, 9mm	1 item	0.42	podiatry, neurology	95937	See Note A.
	fiducial screws, set of 4	1 set	558.00	radiation oncology	95937	See Note A.
75020	film, fluoroscopic	1 sheet	3.51	diagnostic radiology, anesthesia	77301	Item may be deleted. May not be typical and may be separately billable. (Screws used for IMRT head fixation device, but typical patient vignette is prostate cancer.)
	flow sensors	1 item	1.51	pulmonary medicine, internal medicine	72265, 76000, 76005	See Note C.
	gold-palladium target	1 item	0.59	pathology	94621	See Note A.
	hallux implant	1 item		podiatry, orthopaedic surgery	88349	See Note B.
	headcover for MRI	1 item	0.05	diagnostic radiology	28293	See Note A.
	inhaler	1 item	0.75	cardiology, internal medicine	70544-70549	See Note C.
	laryngeal mirror	1 item		diagnostic radiology, otolaryngology	93720	Item may be deleted. (May not be "typical" for service.)
	laser fiber	1 item	595.00	urology	92526	See Note A.
	laser fiber cleaving tool	1 item	200.00	urology	52214, 52224, 52317, 52341, 52342, 52343, 52647	See Note A.
	methylocholone chloride	1 dose	48.50	pulmonary medicine, internal medicine	52214, 52224, 52317	See Note B.
53097	Mounting tray	1 each	40.00	radiation oncology, diagnostic radiology	94070	See Note B.
					77334	See Note A.

Table 1
Items Needing Specialty Input for Pricing and Proposed Deletions

2003 PE supply code	2003 PE Supply description	2003 PE Unit	2003 PE unit price	Primary specialties associated with supply item	*CPT code(s) associated with supply item	Status of supply item
	Multi-tine Device needle, 4 inch needle, 4-6 inch	1 item 1 item 1 item		allergy/immunology obstetrics, gynecology obstetrics, gynecology	95004, 95010 59841 57020, 57061, 57065, 57130, 57135, 57510, 57511, 57513	See Note C. See Note C. See Note C.
92015	needle, seldinger	1 item	72.90	diagnostic radiology, multiple other specialties	21116, 24220, 25246, 27093, 27095, 27096, 27370, 27648, 36200, 38790, 42550, 50684, 50690, 51605, 51610, 58340, 68850 96115, 96117	See Note A.
72008	neurobehavioral status - forms average	1 item	5.77	clinical psychologist, multiple other specialties	96115, 96117	See Note C. (Original item price estimated by CPEP member.)
	oximetry sensor probe	1 item	15.00	multiple specialties	94762, conscious sedation package	See Note A.
	penile clamp	1 item	40.70	urology	51725, 51726, 51772, 52000-52010, 52265- 52276, 52281, 52282, 52290, 52300-52315 69020, 69200, 69220, 69400-69420, 69424, 69433, 69610 88355-88358	See Note A.
	Phenol Applicator Kit	1 unit		otolaryngology		See Note C.
75123	primary antibodies	1 slide	3.52	pathology, neurology		See Note C. (Codes utilizing this item being reviewed by CPT)
72005	psych testing - forms average	1 item	2.30	clinical psychologist	96100	See Note C. (Original item price estimated by CPEP member.)
	receive coil			diagnostic radiology	70336	See Note A.
	Ruler	1 each	2.67	radiation oncology, diagnostic radiology	77332	See Note A.
	Scissors and clamp, disposable	1 each	0.62	radiation oncology, diagnostic radiology	77781-77784	Need clamp description and source/pricing for "kit."
	Sealant spray			radiation oncology, diagnostic radiology	77333	See Note C.
92030	Silverman needle	1 item	66.35	urology	54500, 54800	See Note A.
	skin prep, one step	1 item	26.00	cardiology	93025	Need inches used per procedure (196in per roll).
	smoke evacuation cartridge sterile, hand table drape (24x43)	1 item	146.50	obstetrics, gynecology orthopaedic surgery, hand surgery	57460, 57461 26055, 26115, 26160	See Note A. Item deleted. Integral part of hand/upper extremity drape supply item.
	sterilizing tray	1 each	64.00	radiation oncology, diagnostic radiology	77781-77784	See Note A.
	steroid	1 cc	1.29	urology	52283	See Note B.
	sweat cells, 4 in a set	1 set	\$260.00	nurse practitioner, neurology	95923	See Note A.
	thrombectomy device	1 item	600.00	diagnostic radiology	36870	Additional information required. Device is reusable. Need to identify specific PTD single-use accessories (eg, sheath, rotator drive, basket)
	tourniquet, ankle, sterile	1 item		podiatry, orthopaedic surgery	28293	See Note A.
	tourniquet, cuff sterile			orthopaedic surgery, hand surgery	26055, 26115, 26160	See Note A.
	traction straps	1 item	60.00	radiation oncology, diagnostic radiology	77418	See Note A.
	transtelephonic monitor		10.56	cardiology	93733, 93736	See Note A.

*CPT codes and descriptions only are copyright 2003 American medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

Notes:

- A. Item deleted. Reusable per manufacturer and/or PEAC worksheet (if reviewed).
B. Item deleted. Separately billable.
C. Additional information required. Need description and/or source and pricing information.

In addition to reviewing and updating the cost information for supplies in the database, our contractor also recommended database revisions to provide uniformity and consistency in the CPEP supply database. All of the following recommendations are noted in Addendum D:

- *Assignment of supply categories.* In the original CPEP data, a number was assigned to each supply. The contractor has recommended that each supply item also be assigned a "category" to allow for easier selection and sorting of items. We agree and are proposing that supplies be assigned to one of the following 14 categories: Accessory, Diagnostics; Accessory, Equipment; Accessory, Procedure; Booklets/Forms; Cutters, Closures/Cautery; Gown, Drape; Hypodermic/IV; Infection Control; Kit, Pack, Tray; Lab; Office, Grocery; Pharmacy, NonRx; Pharmacy, Rx; and Wound Care, Dressings.

These categories could also be used to establish a new numbering system for supplies. We would assign a letter to each supply category and use this in conjunction with a number (000 through 999) to identify each supply. This would enable specialty groups to identify more easily whether a supply has already been included in the CPEP database and would help ensure uniformity in the items used for calculating practice expenses. If we proceed in the final rule with this proposed method for categorizing supplies, we will assign new identifying numbers to each supply input item and these will be available on our website.

- *Consolidation/standardization of item descriptions.*

When items appear to be duplicative, we are proposing to combine the items. For example, "Mayo stand cover" and "drape, sterile Mayo" have both been changed to "drape, sterile, for Mayo stand". We also have attempted to better describe the supply items in a way that will make identification easier, using a key first word when possible. For example, all catheters are described as "catheter, * * *", all needles are described as "needle * * *." In addition, references to proprietary or trademark names for multisource items have been included as parenthetical references (for example, "Polibar™" is renamed barium suspension "(Polibar™)."

- *Standardization of unit descriptions.*

The current CPEP database contains over 72 unit descriptions associated with supplies (for example, item, gram, and cup). To provide consistency and ensure that inputs in the database accurately reflect the quantity of an item used, we are proposing to standardize the unit description of items. If an item is intended for single use, even if it is not completely used, we propose to identify this by indicating the item size followed by "uou" (unit of use). For example "soap bath" has been renamed "bath soap (one bar uou)" and "bacitracin unit dose pack, 9g" has been renamed "bacitracin oint (0.9 gm uou)".

We welcome any comments on the proposed pricing and all other proposed revisions. To help us evaluate the information provided, comments should include documentation such as information from a supply catalog or website or from a current invoice.

h. Miscellaneous Practice Expense Issues

Hyperbaric Oxygen Services

We have received a request from a freestanding hyperbaric oxygen center to price the service in the office setting, so that those providing this service in a nonfacility can receive an appropriate payment. Therefore, we are proposing to assign on an interim basis the following practice expense inputs to CPT code 99183, *Physician attendance and supervision of hyperbaric oxygen therapy, per session*:

Staff: Respiratory Therapist for 135 minutes (for a 2 hour treatment).

Supplies: Minimum Visit Supply Package, 180 liters of oxygen, 187 cubic feet of air.

Equipment: Hyperbaric chamber.

We will request that the Practice Expense Advisory Committee review these inputs at a meeting in the near future.

Maxillofacial Prosthetics PE/hour

In the November 2, 1998 final rule (63 FR 58824), we created a special practice expense pool for maxillofacial prosthetics (CPT codes 21076 through 21087) using the "all physician" practice expense per hour. Because the practice expense survey submitted in 1998 by the American Academy of Maxillofacial Prosthetics (AAMP) differed significantly in format and content from the SMS survey, we were not able to use the submitted data to calculate a practice expense per hour for maxillofacial prosthetics. AAMP has contended that the "all physician" rate underestimates the high costs for the

staff, supplies and equipment associated with the provision of maxillofacial prosthetic services.

We have asked our contractor, The Lewin Group, to analyze the submitted survey data to determine if the data would or would not support a change in the crosswalk for this specialty. The Lewin Group's finding suggests, "the all-physician average may underestimate the practice expense per hour for maxillofacial prosthodontists." Based on the Lewin Group's finding, we reviewed the Medicare utilization of the maxillofacial prosthetics codes. Oral surgeons (specialty code 19) and maxillofacial surgeons (specialty code 85) overwhelmingly provide these services. We believe the practice expenses for these practitioners are likely to be similar to otolaryngologists since these physicians also provide office procedures affecting the head and face. We are proposing to eliminate the special practice expense pool for procedure codes 21076 through 21087 and use otolaryngology as the crosswalk for oral surgeons and maxillofacial surgeons as a more appropriate approximation of the specialties' practice expense per hour. This proposal will increase payment for the maxillofacial prosthetics and other services that are predominantly billed by oral and maxillofacial surgeons. There will be no impact on payment for services provided by any other specialty from this change.

Holter Monitoring Codes

A representative of an independent diagnostic testing facility has communicated to us that their review of the practice expense inputs for the holter monitoring codes, CPT 93225, 93226, 93231, and 93232 has revealed the inclusion of items that are not needed to perform these services. The correspondent suggested the following deletions:

- For CPT codes 93225 and 93231 delete the ECG electrodes and laser paper, as well as the electric bed, computer and holter monitor; and

- For CPT codes 93226 and 93232 delete the razor, nonsterile gloves, alcohol swab and tape, as well as the electric bed and exam table.

We agree that these revisions appear reasonable and will make the above deletions on an interim basis until the PEAC can review these codes. It should be noted these codes are currently in the nonphysician work pool and that the CPEP data is not currently used to calculate their practice expense RVUs. Therefore, these changes will not at this time have any effect on the payment for these codes.

B. Geographic Practice Cost Index Changes

1. Background

The Act requires that payments vary among Medicare physician fee schedule (MPFS) areas according to the extent that resource costs vary as measured by the Geographic Practice Cost Indices (GPCIs). In general, the MPFS areas that existed under the prior reasonable charge system were retained under the MPFS from calendar years 1992 through 1996. We implemented a comprehensive revision in MPFS payment areas (localities) in 1997, reducing the number of localities from 210 to 89. Thirty-four states have a single statewide locality. In contrast, under the hospital inpatient prospective payment system (IPPS), costs are adjusted across more than 350 metropolitan statistical areas (MSAs).

A detailed discussion of the MPFS payment localities can be found in the July 2, 1996 proposed rule (61 FR 34615) and the November 22, 1996 final rule (61 FR 59494).

2. Implication of GPCIs for Rural Areas

The GPCIs do not affect total national payments under the MPFS, but instead distribute payments among areas according to area cost differences. In general, the data show that urban areas usually have higher costs, while rural areas have generally lower costs. Thus, on average the costs associated with operating a private medical practice, as measured by factors such as wages and rent, are higher in urban areas. Alternatively, the average costs associated with the operation of a private medical practice in a rural area are lower. Since the costs associated with operating a private medical practice are measurably different based upon geographic location, varying payments according to the GPCIs will benefit lower cost areas, usually rural, since the law provides that only one-quarter of the area cost difference in physician work, the largest of the three fee schedule GPCI components, be recognized. We believe this was an attempt by the Congress to shift

payments to rural areas. Thus, about 40 percent of MPFS payments ($.75 \times .52$) are by statute not adjusted for area cost differences. Additionally, one component of the practice expense GPCI, supplies, equipment and other, is also, by statute, not adjusted for area cost differences. Supplies, equipment and other represent about 13 percent of total physician resource costs. This means that, effectively, there is a nationwide MPFS for about 53 percent of the average physician payment (40 percent physician work, 13 percent supplies, equipment and other). That is, only about 47 percent of overall physician payment is adjusted for area resource cost differences. In addition, 34 states are statewide payment localities in which all physicians, whether urban or rural, are paid the same. All of these factors shift payments from higher cost, usually urban, areas to lower cost, usually rural areas.

3. GPCI Composition

Section 1848(e)(1)(C) of the Act requires us to review, and if necessary, adjust the GPCIs at least every 3 years. This section of the Act also requires us to phase in the adjustment over 2 years and implement only one-half of any adjustment if more than 1 year has elapsed since the last GPCI revision. The GPCIs were first implemented in 1992. The first review and revision was implemented in 1995, the second review was implemented in 1998, and the third review was implemented in 2001. The next GPCI review and revision is scheduled for implementation in 2004. However, as will be discussed in more detail, because the work and practice expense GPCIs rely primarily on special tabulations of U.S. Census data not yet available, review and revision of only the malpractice GPCI component will be implemented in 2004. Review and revision of the work and practice expense GPCIs will be implemented in 2005.

Currently, only one data source is available for the practice expense GPCI (relative cost of office rent space

collected by the Department of Housing and Urban Development (HUD)). Since we have not received the primary data upon which practice expense GPCIs are calculated and since the office rent component of the practice expense GPCI has proven not to be very substantial in past GPCI updates (it accounts for approximately 11.0 percent of the total GPCI calculation and is phased in over a two year period), we have decided not to revise the practice expense GPCIs for 2004. The work GPCI relies solely on data collected from the 2000 U.S. Census that is not yet available, so we are not able to propose updates to the work GPCI in this proposed rule.

Although there are general discussions of both the background and composition of all three GPCI components in this proposed rule, a detailed discussion of only the 2004 revised malpractice GPCI is included in this proposal while a detailed discussion of the revised work and practice expense GPCIs will be included in the 2005 proposed rule.

4. Development of the Geographic Practice Cost Indices

The GPCIs were developed by a joint effort of the Urban Institute and the Center for Health Economics Research under contract to CMS. The resource inputs and their weights are obtained from the AMA's Socioeconomic Characteristics of Medical Practices Survey. Indices were developed that measured the relative cost differences among areas compared to the national average in a "market basket" of goods. In this case, the market basket consists of the resources involved in operating a private medical practice. The resource inputs are physician work or net income; employee wages; office rents; medical equipment, supplies, other miscellaneous expenses; and malpractice insurance. Employee wages, rents, and miscellaneous expenses are combined to comprise the practice expense component of the GPCI. Table 2 below illustrates the cost share weights that have been utilized for each GPCI update:

TABLE 2.—GPCI (MEDICARE ECONOMIC INDEX) COST SHARE WEIGHTS

Expense category	1992–94*	1995–97**	1998–00**	2001–03***	2004–07****
Physician Earnings	54.2	54.2	54.2	54.5	52.466
Practice Expenses	40.2	41.0	41.0	42.3	43.669
Employee Wages	15.7	16.3	16.3	16.8	18.654
Rents	11.1	10.3	10.3	11.6	12.209
Equip., Supplies, Other	13.4	14.4	14.4	13.9	12.807
Malpractice Insurance	5.6	4.8	4.8	3.2	3.865
	100.0	100.0	100.0	100.0	100.000

*Weights from 1987 AMA survey.

**Weights from 1989 AMA survey.

***Weights from 1997 AMA survey

****Weights from Physician Socioeconomic Statistics, 2000–2002 Edition (SMS Survey), Physician Socioeconomic Statistics, 2003 Edition (PCPS Survey), Center for Health Policy Research, American Medical Association; 2003 Employment Cost Index, U.S. Department of Labor, Bureau of Labor Statistics; U.S. Department of Commerce, Bureau Economic Analysis 1997 Benchmark Input Output Tables, and U.S. Department of Commerce, Bureau of the Census, 2002 Current Population Survey. (See section III.A. Rebasing and Revising of the Medicare Economic Index.)

The Medicare economic index (MEI) is a measure of the average increases in the price of inputs used in operating a private medical practice and is used in the annual update of the MPFS CF. Because the GPCIs and the MEI use the same resource inputs to measure the costs of a private medical practice (the GPCIs measure relative costs among areas while the MEI measures the national average rate of increase in prices), as in the past, the same weights will be used for both the MEI and the GPCIs.

Once the components and their weights were determined, we had to find data sources that were widely and consistently available to measure costs in all MPFS payment areas. After examining many sources, the following proxies were selected as the best available sources for measuring each component of the original 1992 through 1994 GPCIs:

- Physician work—The median hourly earnings, based on a 20 percent sample of 1980 census data, of workers in six professional specialty occupation categories (engineers, surveyors, and architects; natural scientists and mathematicians; teachers, counselors, and librarians; social scientists, social workers, and lawyers; registered nurses and pharmacists; writers, artists, and editors) with 5 or more years of college. Adjustments were made to produce a standard occupational mix in each area. The actual reported earnings of physicians were not used to adjust geographical differences in fees because these fees are, in large part, the determinants of the earnings. We believe that the earnings of physicians will vary among areas to the same degree that the earnings of other professionals vary.

- Employee wages—Median hourly wages of clerical workers, registered nurses, licensed practical nurses, and health technicians were also based on a 20 percent sample of 1980 census data.

- Office rents—Residential apartment rental data produced annually by the Department of Housing and Urban Development (HUD) were used because there were insufficient data on commercial rents across all physician fee schedule areas.

- Equipment, supplies, other expenses—The Urban Institute and the Center for Health Economics research

assumed that a national market represents this component and that costs do not vary appreciably among areas. This component's index is 1.000 for all areas to indicate no variation from the national average.

- Malpractice—Premiums in 1985 and 1986 for a mature “claims made” policy (a policy that covers malpractice claims made during the covered period) providing \$100,000 to \$300,000 of coverage were used. Adjustments were made to incorporate the costs of \$1 million to \$3 million coverage and mandatory patient compensation fund (PCF) requirements. Some States legally require physicians to join a PCF that provides coverage for catastrophic claims. Premium data were collected for physicians in three risk classes: low-risk (general practitioners who do not perform surgery), moderate risk (general surgeons), and high-risk (orthopedic surgeons).

The areas selected for measurement purposes were the MSAs. Non-MSA areas within a State were aggregated into one residual area. Using MSAs for measurement satisfied our criteria to have (1) areas in which resource input prices were homogenous, and (2) areas of a large enough size so that market areas are self-contained to minimize border crossing; that is, physicians would probably not move their offices a few miles to secure higher payments and patients who would tend to receive services within their area.

The Act requires, however, that the GPCIs reflect cost differences among MPFS payment areas. Thus, it was necessary to map Medicare localities to the MSA and non-MSA aggregation of GPCI data. Where localities crossed MSA boundaries, MSA indices were converted to Medicare locality indices by population weights.

Detailed discussions of the methodology and data sources of the 1992 through 1994 GPCIs can be obtained by requesting studies from the National Technical Information Service by calling 1–800–553–NTIS, or, for residents of Springfield, Virginia, (703) 487–4650. The studies are as follows:

- The Urban Institute report “The Geographic Medicare Index: Alternative Approaches,” NTIS PB89–216592;
- The supplement to “The Geographic Medicare Index: Alternative Approaches,” NTIS PB91–113506. This

was published in the **Federal Register** in the September 4, 1990 notice (55 FR 36238) for the model fee schedule; and

- The Urban Institute report, “Refining the Malpractice Geographic Practice Cost Index,” February 1991, NTIS PB91–155218. The related diskette is NTIS PB91–507491. This is the final version of the 1992 through 1994 GPCIs as published in the **Federal Register** in the November 25, 1991 final rule (56 FR 59785).

5. Revised 1995 Through 1997 Geographic Practice Cost Indices

The main criticism of the original GPCIs, that existed from 1992 until 1994, was that they were outdated because they were based on old data; for example, 1980 census data and 1985 and 1986 malpractice premium data, was the most recent data available when the GPCIs were established. The revised 1995 through 1997 GPCIs were based on the most current data available when they were developed in 1993 and 1994. We also made some minor changes from the original GPCI methodology in calculating some of the revised 1995 through 1997 indices.

One methodological change was made that applied across all indices. As mentioned earlier, under the original GPCIs, where Medicare payment localities crossed MSA boundaries, MSA indices were converted to locality indices by population weights. Medicare expenditure weights were not used because the expenditures under the reasonable charge system contained large differences unrelated to actual resource cost differences among areas. In calculating the revised GPCIs, where payment localities crossed MSA boundaries, locality indices were calculated by weights based on full MPFS RVUs, which reflect resource cost differences among areas. Full MPFS RVUs were used rather than actual 1993 payments because 1993 fee schedule payments still reflected some reasonable charge payment levels. The advantages of RVU weighting are (1) the GPCIs will more closely reflect physician practice costs in the area where the services are provided rather than where the population lives, and (2) budget neutrality is preserved when we combine multiple payment localities into larger areas, such as statewide localities.

a. Work Geographic Practice Cost Indices

Data from the 20 percent sample of census data of median hourly earnings for the same six categories of professional specialty occupations as used in the 1992 through 1994 work GPCIs were used in calculating the 1995 through 1997 work GPCIs. The 1992 through 1994 work GPCIs were calculated using 1980 census data of earnings for professionals with 5 or more years of college. That sample was no longer available with the 1990 census. The 1990 census educational classifications are by highest degree earned, rather than the 1980 census classification by years of schooling. Thus, it was not possible to obtain earnings data exactly comparable to the 1980 data.

For 1990, data were available for all-education and advanced-degree samples, but not for 5 or more years of college. We elected to use the all-education sample because its larger sample sizes made it more stable and accurate in the less populous areas. Although it could be argued that physicians' earnings might more closely approximate the earnings of professionals with advanced degrees, the differences between the all-education and advanced-degree indices were negligible in all but a few of the smallest localities. We believed that the small sample sizes of advanced-degree occupations in these small localities would produce inaccurate results.

The 1992 through 1994 work GPCIs used metropolitan-wide median wages for each county within an MSA. That is, all counties within an MSA were assigned the MSA-wide median wage even if there were wage variations within the MSA. We believed that this was appropriate for all but Consolidated Metropolitan Statistical Areas (CMSAs), the largest of the MSAs, such as New York. In these CMSAs, we replaced metropolitan-wide earnings with county-specific earnings. We believed this change was appropriate because costs were, in fact, higher in central city areas (for example, Manhattan and San Francisco) than in the rest of the CMSA. County earnings were a better account of the cost variation within these large metropolitan areas.

b. Practice Expense Geographic Practice Cost Indices

(1) Employee Wage Indices.

Data from the 20 percent sample of census data of median hourly earnings for the same categories of medical and clerical occupations used in the 1992 through 1994 practice expense GPCIs

were also used in the 1995 through 1997 practice expense GPCIs. The 1995 through 1997 practice expense GPCIs used 1990 rather than 1980 census data. As with the work GPCIs, county level data were used for CMSAs to better reflect the cost variations within these large metropolitan areas.

(2) Rent Indices.

As with the original rent indices, the HUD fair market rental (FMR) data for residential rents were again used as the proxy for physician office rents. The 1995 through 1997 practice expense GPCIs reflect 1994 HUD FMRs. Like the work GPCI and the employee wage index of the practice expense GPCIs, county level data were used in CMSAs to recognize the variations within the CMSA.

The major criticism of the rent indices was that residential rather than commercial rent data were used. As mentioned earlier, for constructing the GPCIs we needed data that were widely and consistently available across all physician fee schedule areas.

As with the original GPCIs, we again searched for private sources of commercial rent data that were widely and consistently available. The private sources we found were not adequate. None of the sources collected data for non-metropolitan areas, nor did any collect data for all metropolitan areas. The sources did not reflect the average commercial space in the area, but rather the particular type of space most relevant to the needs of a particular source's clients. In addition, the sample sizes were small. A comparison of the average rental for any particular city showed significant variation depending upon the source. Also, the private commercial rent data tended to be for very high priced real estate of the type likely to be used by large institutions such as banks, insurance companies, or financial firms and not for the type of office space most likely used by physicians.

Among the sources of commercial rent data that were available, the most promising were data from the Building Owners and Managers Association, the General Services Administration, and the U.S. Postal Service. These data were analyzed in depth. We did not use data from the Building Owners and Managers Association and the General Services Administration because of poor geographic coverage, especially outside of large metropolitan areas. That is, data were not widely and consistently available for all physician fee schedule areas. The U.S. Postal Service data had much better geographic coverage, but sample sizes in many areas were

unacceptably small and could have led to erroneous results.

No acceptable national commercial rent data were readily available for physician office rents. Thus, some proxy needed to be used for this portion of the index. In addition, commercial rent data were not available for all areas from published statistical sources. We believed that the HUD FMR data remained the best available data for constructing the office rental index. HUD FMR data were available for all areas, were updated on an annual basis, and were consistent among areas and from year to year. Moreover, we believed that physicians frequently locate in areas and office space that are residential rather than commercial, for example, in apartment complexes and small strip commercial centers adjacent to residential areas. Residential rents may, in fact, be a better measure of the differences among areas in the physician office market than a general commercial rental index.

(3) Medical Equipment, Supplies, and Miscellaneous Expenses.

Consistent with the original 1992 through 1994 update for medical equipment, supplies, and miscellaneous, this index assumes a national market in which input prices do not vary among geographic areas. We were unable to find any data sources that demonstrated price differences by geographic area. Anecdotal and interview data with suppliers and manufacturers were inconclusive. While some price differences may exist, we believed they were more likely to be based on volume discounts rather than on geographic areas. Generally, it appears that manufacturers' prices do not vary among areas except for shipping costs. Since manufacturers and suppliers are located all over the country, shipping costs do not vary significantly.

c. Malpractice Geographic Practice Cost Indices

Again, malpractice premium data for a \$1 million to \$3 million mature "claims made" policy were collected, with mandatory Patient Compensation Funds (PCFs) considered. Some States have legally required physicians to join PCFs that provide coverage for catastrophic claims. The PCF charges a premium or surcharge just as any other insurer. However, more recent and more comprehensive malpractice insurance data were used in calculating the 1995 through 1997 malpractice GPCIs. The 1995 through 1997 malpractice GPCIs were based on 1990 through 1992 malpractice premium data. Since malpractice premiums may change

significantly from year to year, we decided to use the most recent 3-year average available rather than just the most recent single year to smooth out this volatility and present a more accurate indication of malpractice premium trends over time.

We collected data on more specialties and from more insurers. We collected data on 20 specialties, rather than on only 3 as in the 1992 through 1994 malpractice GPCIs. The 1992 through 1994 malpractice GPCI data were largely drawn from a single nationwide insurer (St. Paul Fire and Marine) and were supplemented by several State-specific carriers in States in which St. Paul did not offer coverage. Subsequent analyses suggest that these data may not be representative of insurers operating in many States. For the revised malpractice GPCI, data were collected from insurers that, on average, represented 82 percent of the market in each State, with the lowest State market share being 60 percent. We believed that the more recent and much more comprehensive data greatly improved the accuracy of the malpractice GPCIs for 1995 through 1997.

Detailed discussions of the methodology and data sources of the 1995 through 1997 GPCIs can be obtained by requesting the following studies from NTIS by calling 1-800-553-NTIS, or (703) 487-4650 in Springfield, Virginia:

- "Updating the Geographic Practice Cost Index: Revised Cost Shares." Debra A. Dayhoff, John E. Schneider, and Gregory C. Pope. NTIS PB94-161072.

- "Updating the Geographic Practice Cost Index: The Physician Work GPCI." Gregory C. Pope and Deborah A. Dayhoff. NTIS PB94-161080.

- "Updating the Geographic Practice Cost Index: The Practice Expense GPCI." Gregory C. Pope, Deborah A. Dayhoff, Angella R. Merrill, and Killard W. Adamache. NTIS PB94-161098.

- "Updating the Geographic Practice Cost Index: The Malpractice GPCI." Stephen Zuckerman and Stephen Norton. NTIS PB94-161106.

6. Revised 1998 Through 2000 Geographic Practice Cost Indices

The same data sources and methodology used for the 1995 through 1997 GPCIs were also used for the revised 1998 through 2000 GPCIs with a few very minor modifications. No acceptable additional data sources were found. The cost shares were the same as in the 1995 through 1997 GPCIs because no changes were made in the MEI weights. Indices for fee schedule areas were based on the indices for the individual counties within the fee

schedule area. Fee schedule RVUs were again used to weight the county indices (to reflect volumes of services within counties) when mapping to MPFS payment areas and in constructing the national average indices. However, we used more recent data, 1994 rather than 1992 RVUs, in the county, locality, and national mapping for the proposed GPCIs. The payment effect of using more current RVU weights was negligible in most cases and generally resulted in changes at the third decimal point if at all.

a. Work Geographic Practice Cost Indices

The work GPCIs were based on the decennial census. The 1992 through 1994 work GPCIs were based on 1980 census data, because 1990 census data were not yet available. The work GPCIs were revised in 1995 with new data from the 1990 census. New census data will not be available again until sometime after the 2000 census is compiled. We searched for other data that would enable us to update the work GPCIs between the decennial censuses. No acceptable data sources were found. The most promising sources of data were the hospital wage data collected by us to calculate the IPPS hospital wage index and the payroll per worker data collected by the U.S. Bureau of Labor Statistics from State unemployment insurance agencies (the ES-202 data).

The IPPS hospital wage data were examined when we constructed the original GPCIs. They were rejected as a physician fee schedule data source in favor of census data because of their lack of an occupation mix adjustment and their unrepresentative occupational composition (hospital employees rather than professionals or physician office employees). ES-202 data consist of total payroll divided by counts of wage and salary workers. The major disadvantage we identified was that they do not measure hourly earnings, only payroll per employee, and no occupational detail is available. Also, they did not adjust for part-time or full-time and hours worked, and the numbers of workers was too small for certain States, all of which led to unstable estimates of payroll per worker. We compared the changes by State from 1989 to 1993 in the IPPS wage data and the ES-202 data to see if there was any correlation between the two series. The correlation between the two was only moderate, 0.55. The changes indicated by both series were generally small, for example, a few percentage points. The difference between the two series by State was in many cases as large as or greater than the change indicated by either series.

The average difference between the two series (2.1 percent) is as large as the change indicated by either series. In addition, changes for particular States were substantially different between the two series. For example, Indiana relative wages rose by 1.9 percent according to the IPPS data, but fell 5.7 percent according to the ES-202 data.

Since we were unable to find an acceptable data source for updating the work GPCIs, we examined the consequences of not updating the work GPCIs between the decennial censuses. We compared the changes between the 1992 through 1994 work GPCIs, based on the 1980 census, and the 1995 through 1997 GPCIs, based on the 1990 census. On average, the full variation in State work GPCIs changed by about 5 percent. This translates to about a 1.2 percent change in the one-quarter work GPCI calculation prescribed by law. Since work makes up about one-half of the GPCI cost shares, this translated into an average payment change per State of about 0.6 percent from updating the work GPCI based on the 10-year change in relative wages indicated by the census data. Even the maximum change in the full variation in State work GPCIs from the 1992 through 1994 to the 1995 through 1997 GPCIs of 14 percent translates into only about a 1.8 percent change in payments. The largest full work GPCI changes for individual payment areas were from 16 to 20 percent, or about a 4 to 5 percent change in the one-quarter work GPCI, or about a 2.4 percent change in payments. However, 80 percent of payment areas experienced payment changes of less than 1 percent, and 50 percent of payment localities experienced payment changes of less than 0.5 percent as a result of changes in the census data from 1980 to 1990.

We, therefore, made no changes in the 1998 through 2000 work GPCIs from the 1995 through 1997 work GPCIs, other than the generally negligible changes resulting from using 1994, rather than 1992, RVUs for this GPCI update because we were unable to find acceptable data for use between the decennial censuses. We believed it is preferable that we make no changes rather than make inaccurate changes based on inappropriate data. We felt that this was a reasonable position given the generally small magnitude of the changes in payments resulting from the changes in the work GPCIs from the 1980 to the 1990 census data.

b. Practice Expense Geographic Practice Cost Indices

(1) Employee Wage Indices.

As with the work GPCIs, the employee wage portion of the practice expense GPCIs were also based on decennial census data. For the same reasons discussed above pertaining to the work GPCIs, we made no changes in the employee wage indices during the 1998 through 2000 GPCI update. The average change from the 1992 through 1994 to 1995 through 1997 employee wage indices across States was about 6 percent. Since the employee wage index has a weight of about 16 percent in the GPCI cost shares, this translates into a 1 percent average change in payments. The maximum payment change in any payment area resulting from changes from the 1992 through 1994 to 1995 through 1997 employee wage indices was about 3.2 percent. Payment changes in over two-thirds of the payment areas were less than 1 percent.

(2) Rent Indices.

The office rental indices were again based on HUD residential rent data. The rental indices were based on 1996 HUD data as opposed to 1994 HUD data in the 1995 through 1997 GPCIs. HUD made two small methodological changes in developing the data. First, HUD used the 40th percentile of area rents rather than the 45th percentile. This did not materially affect the GPCIs, which measure relative rents among areas. Second, HUD established a rental floor for rural counties at the statewide rural average. This had the effect of raising the office rental indices slightly in rural areas.

We made one methodological change in the rent indices. HUD publishes FMRs only for metropolitan areas as a whole. For the 1995 through 1997 GPCIs, HUD used a special tabulation of the 1990 census data to allocate rents by county within CMSAs. In some metropolitan areas, this had the effect of reducing the central city index below the suburban index, probably because of lower unmeasured housing quality in central cities than in suburbs. We did not feel that this was a representative indicator of relative physician rents, since the GPCIs are intended to measure rental costs for offices of similar quality in different areas. The metropolitan-wide rent was most appropriate for measuring the cost of space of an average quality across the metropolitan area, which is why HUD publishes only metropolitan-wide FMRs. Also, the census county adjustments can be updated only once every 10 years. For this reason, we believed that the county-specific adjustment should not be made for all large metropolitan areas but should be retained only for the New York City Primary Metropolitan Statistical Area. Available evidence

suggests that rents vary substantially among the boroughs of New York City and that, given the current locality configuration, the county-specific rental adjustment appropriately reflects these patterns in the New York City area, especially the higher rents in Manhattan.

(3) Medical Equipment, Supplies, and Miscellaneous Expenses. As with the 1992 through 1994 and 1995 through 1997 GPCIs, this component was given a national value of 1,000, indicating no measurable difference among areas in costs.

c. Malpractice Geographic Practice Cost Indices.

Again, malpractice premium data were collected for a mature "claims made" policy with \$1 million to \$3 million limits of coverage, with adjustments made for mandatory patient compensation funds. As with the 1995 through 1997 GPCIs, data were collected for the 20 largest Medicare-billing physician specialties. The premium data represent at least 50 percent of the market in each State. Again, we used an average of the 3 most recent premium years to smooth out the considerable year-to-year fluctuations that can occur in malpractice premiums. The revised 1998 through 2000 malpractice indices were based on 1992 through 1994 premium data, the latest years available when this revision was being conducted in 1995 through 1996, compared to the 1990 through 1992 data used in the current 1995 through 1997 indices. Another change from the 1995 through 1997 indices is that the specialty shares of the 20 specialties were weighted by fee schedule RVUs rather than allowed charges.

Detailed discussions of the methodology and data sources of the 1998 through 2000 GPCIs may be obtained by requesting the following study from NTIS by calling 1-800-533-NTIS, or, for residents of Springfield, Virginia, (703) 487-4650: "Second Update of the Geographic Practice Cost Index." Gregory C. Pope and Killard W. Adamache.

7. Revised 2001-2003 Geographic Practice Cost Indices

The same data sources and methodology used for the 1998 through 2000 GPCIs were used for the 2001 through 2003 GPCIs. No acceptable additional data sources were found. The only changes from the 1998 through 2000 GPCI were in the cost shares and RVU weighting. As shown in the cost share table in the discussion of the development of the GPCIs, the cost shares were changed to reflect the

revisions in the MEI. This does not affect the work or malpractice GPCIs since they are stand-alone indices (not composed of multiple indices). This cost share revision has a slight effect on the practice expense GPCIs because it changes slightly the weights among the employee wage, rents and miscellaneous components of the practice expense index. We used more recent RVU data, 1998 rather than 1994, in the county, locality, and national mapping in the proposed GPCIs. The payment effect of this was generally negligible.

a. Work Geographic Practice Cost Indices.

For the same reasons discussed in the section on the 1998 through 2000 work GPCIs, no changes were proposed in the work GPCIs, other than the generally negligible changes resulting from the use of 1998 rather than 1994 RVUs for weighting, because we were unable to find acceptable data for use between the decennial census.

b. Practice Expense Geographic Practice Cost Indices

(1) Employee Wage Indices.

As with the work GPCIs, the employee wage indices were based on decennial census data. For the same reasons discussed above pertaining to the work GPCIs, we proposed no changes in the employee wage indices during this GPCI update.

(2) Rent Indices.

The office rental indices were again based on HUD residential rent data. No changes were made in the methodology. The proposed rental indices were based on 2000 rather than 1994 HUD data.

(3) Medical Equipment, Supplies, and Miscellaneous Expenses. As with all previous GPCIs, this component is given a national value of 1,000, indicating no measurable differences among areas in costs.

c. Malpractice Geographic Practice Cost Indices

The same methodology described in the 1998 through 2000 malpractice GPCI section was used in the revision of malpractice GPCIs section for 2001 through 2003, the only difference being the use of more recent data. The malpractice indices were based on 1996 through 1998 malpractice premium data rather than the 1992 through 1994 malpractice premium data that was used in the previous GPCI update.

8. Proposed 2004 through 2007 Geographic Practice Cost Indices

The main criticism of the 2001 through 2003 GPCIs was that they were

outdated because they were based on old data; for example, 1990 decennial census data and 1996 through 1998 malpractice premiums, the most recent data available when the GPCIs for 2001 through 2003 were established. The calculation of the proposed 2004 through 2007 GPCIs will be based upon the same data sources and methodology, but the 2004 through 2007 GPCIs will utilize more current data: 2000 decennial census data, 2000 HUD fair market rental (FMR) data for residential rents, and 1999 through 2003 malpractice premium data. This should address the criticism of the 2001 through 2003 GPCIs being out of date.

a. Proposed Work Geographic Practice Cost Indices

We have not yet received the 2000 decennial census data that will be utilized for the revision of the work GPCIs. For this reason, revisions to the work GPCIs will be included in the proposed rule for calendar year 2005.

b. Proposed Practice Expense Geographic Practice Cost Indices

We have not yet received the 2000 decennial census data that will be utilized for the revision of the majority of the practice expense GPCI. We have obtained 2000 HUD fair market rental (FMR) data for residential rents that is utilized for a portion of the practice expense revision. Since we have not received the primary data upon which practice expense GPCIs are calculated and since the office rent component of the practice expense GPCI has not proven to be a substantially variable component in past GPCI updates and accounts for only approximately 12.0 percent of the total GPCI calculation (phased in over a two year period), we have decided not to revise the practice expense GPCIs now based on our limited data. For these reasons, revisions to the practice expense GPCIs will be included in the proposed rule for calendar year 2005.

c. Proposed Malpractice Geographic Practice Cost Indices

The malpractice GPCI is the most volatile of the three indexes with relatively large variations existing between localities. Malpractice premium data for a \$1 million to \$3 million mature "claims made" policy were collected, with mandatory patient compensation funds considered.

However, due to the recent concerns regarding the escalating cost of professional liability insurance, especially in 2002 and 2003, we will be collecting more recent malpractice premium data. We propose using actual 1999 through 2002 malpractice premium data and projecting the malpractice premium rates for 2003. The methodology for forecasting 2003 medical malpractice premiums will consist of calculating the geometric mean rate of growth between 1999 through 2002 and applying that rate to the 2002 premium. We will also obtain a national aggregate malpractice premium series with which to benchmark the 2003 forecast. At this point, we are still collecting the 2002 malpractice premium data and are thus unable to project 2003 malpractice premium data in this proposed rule. We are proposing to base the malpractice GPCIs upon actual 2001 and 2002 malpractice premium data and projected 2003 malpractice premium data by January 1, 2004. These revised malpractice GPCIs will be published in this year's final physician fee schedule regulation. They will be considered interim and subject to public comment.

9. Payment Localities

We are also interested in receiving comments on the composition of the current Medicare physician payment localities (89 separate payment localities) to which the GPCIs are applied. For additional information regarding the composition of the 89 Medicare physician payment localities please refer to both the July 2, 1996 proposed rule (61 FR 34615) and the November 22, 1996 final rule (61 FR 59494) for the Medicare physician fee schedule.

C. Coding Issues

1. Payment Policy for CPT Tracking Codes

In the November 1, 2001 final rule (66 FR 55269), we stated that carriers have discretion for coverage and payment of services described by CPT tracking codes, also known as CPT Category III codes, unless we have made a national coverage determination (NCD). (These CPT Category III codes are distinct from the HCPCS Level III codes used by local claims processors which are to be discontinued under HIPAA implementation.) We have received several requests to create national

payment amounts for some CPT tracking codes even if there has been no NCD with respect to the services. After review of these requests, we are proposing to change our policy regarding payment for CPT tracking codes.

We propose to create national payment policy and determine national payment amounts for CPT tracking codes when there is a significant programmatic need for us to do so. Such a need could arise, for example, if we receive requests from carrier medical directors that we establish a national payment amount because of carrier inability to do so. This policy change would not change the contractor's discretion over coverage for the CPT tracking codes, but would establish a payment level if the contractor finds that coverage is warranted. Carriers do not need to establish a payment amount for a tracking code until they receive a claim for the code.

2. Excision of Benign and Malignant Lesions

In the CPT 2003 book, the definitions for excision of benign lesions (CPT codes 11400 through 11446 inclusive) and excision of malignant lesions (CPT codes 11600 through 11646 inclusive) were substantively changed. Starting in 2003, these codes are to be reported based on the excised diameter (actual skin removed) rather than on the size of the lesion. We have reviewed the new code descriptors and are proposing to make the work RVUs the same for removal of all skin lesions with the same excised diameters that are from the same area of the body, whether the lesions are benign or malignant. For example, the work RVUs for the removal of benign skin lesions from the trunk, arms or legs with excised diameter 1.1–2.0 cm, CPT code 11402, would be the same as the work RVUs for CPT code 11602, which is the removal of *malignant* skin lesions from trunk, arms or legs with excised diameter of 1.1–2.0 cm. Therefore, to retain budget neutrality within each code pair, the total work RVUs associated with each code pair will be constant both before and after the work adjustment. We will accomplish this by dividing the total 2003 work RVUs (2003 work RVUs for a given code pair multiplied by 2002 utilization) by the total 2002 utilization for the given code pair. For example:

CPT code	2002 utilization	2003 work RVU	Total work RVUs
11400	69,041	0.85	58,685

CPT code	2002 utilization		2003 work RVU		Total work RVUs
11600	13,768	×	1.31	=	18,036
Total	82,809			76,721

76,721 divided by 82,809 = 0.93 work RVU

The proposed work RVUs for these codes follow:

The proposed work RVUs for these codes follow:

TABLE 3

*CPT CODE	Description	2003 work RVU	Proposed Work RVU
11400	Exc tr-ext b9+marg 0.5 < cm	0.85	0.93
11401	Exc tr-ext b9+marg 0.6-1 cm	1.23	1.44
11402	Exc tr-ext b9+marg 1.1-2 cm	1.51	1.72
11403	Exc tr-ext b9+marg 2.1-3 cm	1.79	1.97
11404	Exc tr-ext b9+marg 3.1-4cm	2.06	2.21
11406	Exc tr-ext b9+marg > 4.0 cm	2.76	3.03
11420	Exc h-f-nk-sp b9+marg 0.5 <	0.98	1.01
11421	Exc h-f-nk-sp b9+marg 0.6-1	1.42	1.55
11422	Exc h-f-nk-sp b9+marg 1.1-2	1.63	1.84
11423	Exc h-f-nk-sp b9+marg 2.1-3	2.01	2.28
11424	Exc h-f-nk-sp b9+marg 3.1-4	2.43	2.72
11426	Exc h-f-nk-sp b9+marg > 4 cm	3.78	4.03
11440	Exc face-mm b9+marg 0.5 < cm	1.06	1.16
11441	Exc face-mm b9+marg 0.6-1 cm	1.48	1.89
11442	Exc face-mm b9+marg 1.1-2 cm	1.72	2.31
11443	Exc face-mm b9+marg 2.1-3 cm	2.29	2.86
11444	Exc face-mm b9+marg 3.1-4 cm	3.14	3.78
11446	Exc face-mm b9+marg > 4 cm	4.49	5.57
11600	Exc tr-ext mlg+marg 0.5 < cm	1.31	0.93
11601	Exc tr-ext mlg+marg 0.6-1 cm	1.80	1.44
11602	Exc tr-ext mlg+marg 1.1-2 cm	1.95	1.72
11603	Exc tr-ext mlg+marg 2.1-3 cm	2.19	1.97
11604	Exc tr-ext mlg+marg 3.1-4 cm	2.40	2.21
11606	Exc tr-ext mlg+marg > 4 cm	3.43	3.03
11620	Exc h-f-nk-sp mlg+marg 0.5 <	1.19	1.01
11621	Exc h-f-nk-sp mlg+marg 0.6-1	1.76	1.55
11622	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	1.84
11623	Exc h-f-nk-sp mlg+marg 2.1-3	2.61	2.28
11624	Exc h-f-nk-sp mlg+marg 3.1-4	3.06	2.72
11626	Exc h-f-nk-sp mlg+mar > 4 cm	4.30	4.03
11640	Exc face-mm malig+marg 0.5 <	1.35	1.16
11641	Exc face-mm malig+marg 0.6-1	2.16	1.89
11642	Exc face-mm malig+marg 1.1-2	2.59	2.31
11643	Exc face-mm malig+marg 2.1-3	3.10	2.86
11644	Exc face-mm malig+marg 3.1-4	4.03	3.78
11646	Exc face-mm mlg+marg > 4 cm	5.95	5.57

3. Create G Codes for Monitoring Heart Rhythms

Technological advances have made cardiac telemetry equipment, typically used in hospitals, available in the home setting. It is now possible to discharge patients with arrhythmias to a home setting and have them monitored at home in a manner similar to hospital monitoring. This monitoring can be used to diagnose arrhythmias or to monitor patients with known arrhythmias to determine, on a real-time basis, whether the patient is having ongoing arrhythmias. The equipment consists of patient leads and a home telemetry station that is connected to a distant monitoring station via the telephone. The monitoring station is attended twenty-four hours a day, seven days a week by a technician. Upon receipt of rhythm strips, the technician records and formats the strips and faxes them to the treating physician.

This equipment automatically records the patient's heart rhythm and is not triggered by the patient (for example, his response to symptoms). The equipment is pre-set with parameters (for example, heart rate of over 120) that trigger it to transmit the patient's cardiac rhythm to monitoring station. Additionally, the technician at the monitoring station can interrogate the home station and have it transmit rhythm strips upon request even when no arrhythmia has triggered an automatic transmission. These latter transmissions are at the discretion of the technician and may or may not be faxed to the treating physician based on previous orders.

Depending on the clinical need, patients may be monitored by this equipment for varying lengths of time. Furthermore, the frequency of transmission of cardiac rhythms varies, as does the amount of material that must be reviewed by the physician. For example, a patient may have no cardiac rhythms transmitted for one or more days while on other days the patient may have several minutes of arrhythmias transmitted for physician review.

To ensure this technology is available to Medicare beneficiaries for covered indications (coverage is currently at the discretion of the local Medicare contractors because there is no national coverage determination for this service) we are creating several HCPCS G codes to describe this service and are establishing national payment amounts for these services. Currently Medicare contractors are requiring both the PC and TC of this service to be billed under CPT code 93799, *Unlisted cardiovascular procedure or service*.

This service is covered under the diagnostic test benefit category at section 1861(s)(3) of the Act.

Medicare is establishing the following HCPCS codes to describe this service:

GXXX1—*Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; includes recording, monitoring, receipt of transmissions, analysis, and physician review and interpretation.* (global)

GXXX2—*Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; recording (includes hook-up, recording and disconnection)*

GXXX3—*Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; monitoring, receipt of transmissions, and analysis*

GXXX4—*Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; physician review and interpretation.*

We are establishing the following payment amounts for these codes:

GXXX1—We are assigning 0.52 physician work RVUs and 0.24 malpractice RVUs which is equivalent to *CPT Code, 93268 Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission physician review and interpretation.*

We are also crosswalking the practice expense inputs from CPT Code 93268. **GXXX2**—We are assigning 0.07 malpractice RVUs which is equivalent to *CPT Code 93270, Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; recording (includes*

hook-up, recording, and disconnection) and crosswalking the practice expense inputs from CPT Code 93270.

GXXX3—We are assigning 0.15 malpractice RVUs which is equivalent to *CPT Code 93271, Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmission, and analysis* and also are crosswalking the practice expense inputs from CPT Code 93271.

GXXX4—We are assigning 0.52 physician work RVUs and 0.02 malpractice RVUs which is equivalent to *CPT Code 93272 Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; physician review and interpretation only.* We are also crosswalking the practice expense inputs, from CPT Code 93272.

We believe these proposed RVUs and crosswalks are appropriate as the services provided in the new codes are very similar in terms of physician work, resource use, and malpractice risk to the existing CPT Codes.

4. CPT Code 88180 (Flow Cytometry; Each Cell Surface, Cytoplasmic or Nuclear Marker)

Flow cytometry is a technique to analyze single cell suspensions from blood, bone marrow, body fluids, lymph nodes, and other tissues. The technique, currently coded as CPT code 88180, *Flow cytometry, each cell surface, cytoplasmic or nuclear marker*, quantifies cell surface, cytoplasmic, and nuclear antigens. The results are frequently used to diagnose lymphomas and leukemias. They are also used to monitor lymphocyte subpopulations in patients with HIV infection or solid organ transplantation. For example, in patients with HIV infection, physicians evaluate CD4+ lymphocytes as a measure of the severity of the infection (some physicians also measure other markers although their clinical relevance is not as well established). In patients with solid organ transplantation, physicians measure various lymphocyte subpopulations to help assess early rejection, identify bone marrow toxicity during immunosuppressive therapy, and differentiate infections from transplant rejection. In these cases the treating physician, not the pathologist, makes the diagnosis. It is inappropriate for the pathologist to report the professional component (PC) of this service. In general, flow cytometry results must be utilized along with clinical data to make

a diagnosis. Other clinical situations where flow cytometry tests have some value include stem cell transplantation, paroxysmal nocturnal hemoglobinuria, immune deficiency disorders, etc.

When flow cytometry is performed to diagnose lymphoma or leukemia, there is a single interpretation based on the quantification of all markers tested. There is not an interpretation of each marker individually.

Moreover, for a given clinical indication (for example, diagnosis of lymphoma based on lymph node examination) there is variation in the number of markers performed. The number of markers that are necessary depends, in part, on the pathologic information available to the pathologist at the time he/she orders flow cytometry. Therefore, for a given clinical indication (for example, diagnosis of lymphoma from a lymph node) a pathologist who chooses to perform flow cytometry before performing a microscopic examination of the tissue specimen (for example, a lymph node) may order more markers than a pathologist who orders flow cytometry after performing a microscopic examination of the tissue specimen.

The current coding scheme (payment on a per marker basis) may encourage the performance of more markers than may be medically necessary because the pathologist determines what markers to perform and when to perform them.

Our review of flow cytometry reports confirms that markers are interpreted (and reported) on a panel basis. From our review, physicians do not typically interpret individual markers. This is consistent with most of the clinical indications for flow cytometry that require performance of several markers to make a diagnosis. There may also be clinical situations where no professional component is performed although it is appropriate to perform the technical component (TC) (for example, monitoring of HIV infected patients, monitoring of solid organ transplantations).

The fact that markers are generally analyzed on a "panel" basis, not an "individual" basis, means that the current practice and use of flow cytometry is not appropriately reflected by the PC of CPT code 88180.

However, we do believe that it is appropriate to pay for the TC of each marker separately, although at a lower rate of payment (due to economies of scale) when multiple markers are performed. A coding scheme that pays per marker for the TC and per panel for the PC would more accurately reflect the actual practice of flow cytometry.

The laboratory community is aware of our concerns about the coding of flow cytometry and will review this issue and consider whether changes should be made to the current coding for the procedure. If no changes in coding are forthcoming, we would consider creating HCPCS codes for flow cytometry. We welcome comments and recommendations on appropriate values for the procedure that we could use in developing any future proposal.

5. Create G Codes for Dialysis Patient Seeing the Doctor

We have reviewed our current payment policy for the monthly dialysis capitation, CPT codes 90918 through 90921 in response to concerns that have been raised over whether our payment policy is consistent with current medical practice.

Specifically, we understand that physician involvement in dialysis for end stage renal disease (ESRD) varies based on a patient's condition, response to dialysis, and comorbidities. A physician involvement for a single patient may also vary from month to month. It is our intent to ensure that beneficiaries with ESRD receive the highest quality dialysis care available and that physician involvement in dialysis for ESRD patients is appropriate and consistent with the needs of the patient in any month.

Observers of the quality of care for dialysis patients have noted that some dialysis patients may benefit from being evaluated by their physician frequently. A recent international comparison study suggested that longer physician-patient contact time in hemodialysis facilities was associated with lower mortality risk.

To align the payment incentives with the frequency of the physician personally evaluating the dialysis patient, we are proposing to make CPT codes 90918, 90919, 90920, 90921 invalid for Medicare and to create G codes. We are proposing to create 3 new G codes in place of each CPT code with higher payments associated with providing more visits within each month to an ESRD patient. Under our proposal, there will be separate codes when the physician provides 1 visit per month, 2–3 visits per month and 4 or more visits per month. The code for 1 visit per month will have the lowest payment while a higher payment will be provided for 2 to 3 visits per month and the highest payment for 4 or more visits per month. Our methodology for determining payment is described below. These new codes will be reported once per month for services performed in an outpatient setting and

related to the patient's ESRD. These physician services will continue to include the establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls, and patient management, provided during a full month. These codes would not be used if a hospitalization occurred during the month.

GXXX5—End Stage Renal Disease (ESRD) related services per full month, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.

GXXX6—End Stage Renal Disease (ESRD) related services per full month, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.

GXXX7—End Stage Renal Disease (ESRD) related services per full month, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.

GXXX8—End Stage Renal Disease (ESRD) related services per full month, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.

GXXX9—End Stage Renal Disease (ESRD) related services per full month, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.

GXX10—End Stage Renal Disease (ESRD) related services per full month, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.

GXX11—End Stage Renal Disease (ESRD) related services per full month, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and

counseling of parents; with 4 or more face-to-face physician visits per month.

GXX12—End Stage Renal Disease (ESRD) related services per full month, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.

GXX13—End Stage Renal Disease (ESRD) related services per full month, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.

GXX14—End Stage Renal Disease (ESRD) related services per full month, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month.

GXX15—End Stage Renal Disease (ESRD) related services per full month, for patients 20 years of age and over; with 2 or 3 face-to-face physician visits per month.

GXX16—End Stage Renal Disease (ESRD) related services per full month, for patients 20 years of age and over; with 1 face-to-face physician visit per month.

We are assuming that most physicians will provide 4 or more visits to their ESRD patients and a small proportion will provide 2–3 visits or only 1 visit per month. Using these assumptions and Medicare utilization data from 2002, we developed relative value units for the new G codes that will make the Medicare's aggregate payments for ESRD related services under the physician fee schedule approximately equal to current payments that are occurring using procedure codes 90918 to 90921. Relative to our current payments, we are proposing to lower payment when the physician provides 1 visit per month or 2–3 visits per month. Since we are proposing to lower payment if the physician provides fewer than 4 visits per month, in order to maintain the same aggregate payments for ESRD related services, we are proposing to increase payment if the physician provides 4 or more visits per month. Using these assumptions, the proposed work, practice expense and malpractice RVUs for procedure codes GXXX5 through GXXX16 are shown below:

TABLE 4

Code	Physician work	Practice expense	Malpractice
GXXX5	12.92	8.70	0.60
GXXX6	5.19	3.49	0.24
GXXX7	3.39	2.29	0.16
GXXX8	9.91	4.86	0.43
GXXX9	3.55	1.74	0.15
GXX10	2.32	1.14	0.10
GXX11	8.47	4.54	0.35
GXX12	3.14	1.68	0.13
GXX13	2.05	1.10	0.08
GXX14	5.16	2.94	0.22
GXX15	1.94	1.10	0.08
GXX16	1.27	0.73	0.06

We believe that stratifying payment amounts by physician face-to-face involvement would be an improvement over the current method, but still may not be optimal to foster improved outcomes.

Both the Institute of Medicine and Medicare Payment Advisory Commission (MedPAC) have advocated an increased role for CMS in encouraging improved quality outcomes. In their June 2003 Report to Congress (Variation and Innovation in Medicare), MedPAC recommended “the Secretary should conduct demonstrations to evaluate provider payment differentials and structures that reward and improve quality.”

We responded to this call by increasing the focus of our Quality Improvement Organizations (formerly called Peer Review Organizations) and ESRD Networks on developing quality measures and also performing or assisting providers with the performance of quality improvement activities. We have also implemented initiatives to address the quality of care provided in various settings. These include: The Home Health Quality Initiative; the Hospital Quality Initiative; the Nursing Home Quality Initiative; the Home Health Quality Initiative and Doctors Office Quality Project (see <http://cms.hhs.gov/quality/> for more information).

Additionally, we have developed various demonstration projects that provide incentives to improve quality. For example, as part of an ongoing effort to achieve improved patient outcomes, we announced the ESRD Disease Management Demonstration in the **Federal Register** on June 4, 2003. The goal of this demonstration is to achieve improved patient outcomes through disease management services and quality incentives. This demonstration does not directly involve renal physicians, but we are considering the use of quality incentives in potential

future payment systems for them as well. Renal physicians play a central role in leading the interdisciplinary team charged with managing an ESRD patient's care.

Thus, we are seeking comment on how to further revise our payment methodology to improve quality of care and outcomes. We are also interested in information that could help us design future demonstrations that would incorporate both dimensions of care (quality and utilization) and help ensure that payment is based on appropriate patient-specific care that has been shown to lead to improved outcomes for this complex patient population.

6. Extracorporeal Shock Wave Lithotripsy for Musculoskeletal Conditions

We received several comments on the G codes for extracorporeal shock wave lithotripsy created in the December 31, 2002 final rule. We will be responding to those comments as part of this year's final rule, but we would appreciate any additional information on the physician work, practice expenses, and duration of treatment and intensity or energy of the shock waves applied for various conditions at various anatomic sites.

7. Late RUC recommendations for 2003 CPT codes.

RUC recommendations for RVUs for approximately 20 new CPT codes for 2003 were received too late for incorporation in the December 31, 2002 final rule. We proposed interim RVUs for these codes and, as with all interim values, these were subject to comment. In their comments on the December 2002 final rule, the AMA–RUC requested that we consider their late recommendations for these codes. We will be addressing these, as well as other comments received on the interim RVUs in the upcoming final rule.

III. Other Issues

A. Rebasement and Revising of the Medicare Economic Index

1. Background

The Medicare Economic Index (MEI) is required by section 1842(b)(3) of the Act, which states that prevailing charge levels beginning after June 30, 1973 may not exceed the level from the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that the higher level is justified by year-to-year economic changes. Beginning July 1, 1975, and continuing through today, the MEI has met this requirement by reflecting the weighted sum of the annual price changes of the inputs used

to produce physicians' services. As such, the MEI attempts to be an equitable measure of price changes associated with physician time and operating expenses.

The current form of the MEI was detailed in the November 25, 1992 **Federal Register** (57 FR 55896) and was based in part on the recommendations of a Congressionally-mandated meeting of experts held in March 1987. Since that time, the structure of the MEI has remained essentially unchanged, with two exceptions. First, the MEI was rebased in 1998 (63 FR 58845), which moved the cost structure of the index from 1992 data to 1996 data. Second, the methodology for the productivity adjustment was revised in 2002 (67 FR 80019) to reflect the percentage change in the 10-year moving average of economy-wide multifactor productivity.

We are proposing to rebase and revise the MEI for the 2004 physician fee schedule update. The terms "rebasings" and "revising", while often used interchangeably, actually denote different activities. Rebasings means moving the base year for the structure of costs of an input price index, while revising means changing data sources, cost categories, or price proxies used in the input price index. As is always the case with a rebasing and revising exercise, we have attempted to use the most recently available, relevant, and appropriate information to develop the MEI cost category weights and price proxies. We detail below the updated cost weights for the MEI expense

categories, our rationale for selecting the price proxies in the MEI, and the results of the proposed rebasing and revising of the MEI.

2. Use of More Current Data

The MEI was last rebased and revised in 1998 for the 1999 physician fee schedule update (63 FR 58845). The current base year for the MEI is 1996, which means that the cost weights in the index reflect physicians' expenses in 1996. However, we believe it is desirable to periodically rebase and revise the index so that the expense shares and proxies reflect more current conditions. For this reason, we propose to rebase the MEI to reflect physicians' expenses in 2000. In addition, we are proposing to revise the cost categories in the MEI and to change three of the proxies we currently use to ensure that the index is appropriately reflecting price changes. We will continue to adjust the MEI for economy-wide multifactor productivity.

The expense categories in the proposed MEI were primarily derived from the 2003 AMA Physician Socioeconomic Characteristics publication (2003 Patient Care Physician Survey data), which measures physicians' earnings and overall practice expenses for 2000. The AMA data were used to determine expenditure weights for total expenses, physicians' earnings, and malpractice expenses, the only information detailed in this survey. To further disaggregate into subcategories reflecting more detailed expenses, we used data from

previous AMA surveys, the 1997 Bureau of Economic Analysis Benchmark Input-Output table (I/O), the 2003 Bureau of Labor Statistics (BLS) Employment Cost Index (ECI), and the 2002 Bureau of the Census Current Population Survey (CPS).

3. Rebasings and Revising Expense Categories in the MEI

a. Developing the Weights For Use in the MEI

Developing a rebased and revised MEI requires selecting a base year and determining the number and composition of expense categories. We are proposing to rebase the MEI to CY 2000. CY 2000 was chosen as the base year for two main reasons: (1) CY 2000 was the most recent year for which data were available from the AMA, and (2) we believed that the CY 2000 data were representative of the changing distribution of physicians' earnings and practice expenses over time.

We determined the number and composition of expense categories based on the criteria used to develop the current MEI and other CMS input price index expenditure weights. These criteria are timeliness, reliability, relevance, and public availability. For more information on these criteria, see the May 9, 2002 **Federal Register** (67 FR 31444) and the detail later in this preamble. Table 5 lists the set of mutually exclusive and exhaustive cost categories that make up the proposed rebased and revised MEI.

TABLE 5.—PROPOSED REVISED MEDICARE ECONOMIC INDEX EXPENDITURE CATEGORIES, WEIGHTS, AND PRICE PROXIES

Expense category	Proposed 2000—Expense weights ^{1 2}	1996 Expense weights	Proposed price proxies
Total	100.000	100.000	
Physician Earnings ³	52.466	54.460	
Wages and Salaries	42.730	44.197	AHE—Private.
Benefits ⁴	9.735	10.263	ECI—Ben: Private.
Physician Practice Expenses	47.534	45.540	
Nonphysician Employee Compensation	18.654	16.812	
Employee Wages and Salaries	13.809	12.424	
Prof/Tech Wages	5.887	5.662	ECI—W/S: Private P&T.
Managerial Wages	3.333	2.410	ECI—W/S: Private Admin.
Clerical Wages	3.892	3.830	ECI—W/S: Private Clerical.
Services Wages	0.696	0.522	ECI—W/S: Private Service.
Employee Benefits ⁴	4.845	4.388	ECI—Ben: Priv. White Collar.
Office Expenses	12.209	11.581	CPI(U)—Housing
Professional Liability Insurance	3.865	3.152	CMS—Prof. Liab. Phys. Premiums.
Medical Equipment	2.055	1.878	PPI—Medical Instruments & Equip.
Pharmaceuticals and Medical Materials and Supplies	4.320	4.516	
Medical Materials and Supplies	2.011	PPI Surg. Appliances and Supplies/CPI(U) Med Supplies.
Pharmaceuticals	2.308	PPI Ethical Prescription Preparations.
Other Professional Expenses	6.433	7.601	CPI—U All Items Less Food and Energy.

¹ Due to rounding, weights may not sum to 100.000 percent.

²Sources: Physician Socioeconomic Statistics, 2000–2002 Edition (SMS Survey), Physician Socioeconomic Statistics, 2003 Edition (PCPS Survey), Center for Health Policy Research, American Medical Association; 2003 Employment Cost Index, U.S. Department of Labor, Bureau of Labor Statistics; U.S. Department of Commerce, Bureau of Economic Analysis 1997 Benchmark Input Output Tables, and U.S. Department of Commerce, Bureau of the Census, 2002 Current Population Survey.

³Includes employee physician payroll.

⁴Includes paid leave.

To determine the expenditure weights for the proposed rebased and revised MEI, we used currently available and statistically valid data sources on physician earnings and practice expenses. While we consulted numerous data sources, we used five data sources to determine proposed MEI expenditure weights: (1) The 2003 AMA Physician Socioeconomic Statistics (2000 survey data) for self-employed physicians, (2) the 2000–2002 AMA Physician Socioeconomic Statistics (1998 data) for self-employed physicians, (3) the March 2003 BLS Employment Cost Index, (4) the 2002 Bureau of the Census CPS, and (5) the Bureau of Economic Analysis (BEA) 1997 Benchmark Input-Output tables (I/O). No one data source provided all of the information needed to determine expenditure weights according to our criteria. The development of each of the cost categories using these sources is described in detail below.

b. Physician Earnings

Like the current MEI, the proposed rebased and revised MEI will use AMA data on mean physician net income (physician earnings) for self-employed physicians to develop a weight for physician earnings. The weight for this expense category was based on AMA data for 2000 and was calculated as a percentage of total mean expenses (physician earnings and practice expenses, including malpractice). The physician earnings expenditure category also includes employee physician compensation. Currently, physician earnings and overhead expenses generated by employee physicians are included in the AMA practice expenses category. However, we believe it is appropriate, for our purposes, to place employee physician compensation in the MEI cost category of physician earnings since employee physician compensation represents actual expenditures made in the delivery of services. In addition, including employee physician payroll in physician earnings in the MEI is consistent with the current payment methodologies in accordance with the physician fee schedule, where the work RVU is computed based on what service is provided and not on who provides the service. Since employee physicians perform the same services as self-employed physicians, employee

physician time is reflected in the work RVU. By including the compensation of employee physicians in the physician earnings expense category, these expenses will be adjusted by the appropriate price proxies for a physician's own time.

To obtain further detail for both wages/salaries and benefits, the ratio between these categories for 1996 (based on current MEI) was updated to 2000 using the growth in the overall employment cost index for private employees for wages/salaries and benefits. Alternative data for determining this split were not readily available from any other source. The main shortcoming of this method is that any changes in quantity and intensity (mix of physicians) are not reflected. However, faced with the lack of alternative data, we deemed this approach to be the most feasible, and the results appear to be consistent with anecdotal evidence on this ratio. Its application resulted in a wage-fringe benefit split of 81.4 and 18.6 percent, respectively, in the proposed revised and rebased MEI compared with a wage-fringe benefit split of 81.2 and 18.8 percent, respectively in the 1996-based MEI.

c. Physician Practice Expenses

To determine the remaining individual practice expense weights, we updated AMA expense data from 1998 to 2000 using the relative price change in an appropriate price index. After the levels were updated to 2000 values, it was necessary to normalize these levels to equal the 2000 mean total expense data provided by the 2003 AMA survey. The detailed explanations for the derivation of the individual weights are listed below.

(i) Nonphysician Employee Compensation

The cost share for nonphysician employee compensation was developed by updating the 1998 AMA Socioeconomic Survey data on nonphysician employee compensation costs for self-employed physicians to 2000, using the current proxy for this category, and dividing the resulting amount into total expenses (physician earnings plus practice expenses) for 2000 from the AMA survey. We further divided this cost share into wages/salaries and benefits using BLS

Employment Cost Index data. The ECI survey contains data on the proportion of total compensation accounted for by wages/salaries and benefits (including paid leave) by private industry health services occupational category. These proportions can be used to distribute the total non-physician employee compensation weight to wages/salaries and benefits for non-physician employees. We used 2000 data from the March 2003 publication. Although this survey does not contain data specifically for offices of physicians, data are available on wage/fringe shares for private industry health services, which include hospitals, nursing homes, offices of physicians, and offices of dentists. We believe the data for health services from the survey do provide a reasonable estimate of the split between wages and fringe benefits for employees in physicians' offices. Data for 2000 in the ECI survey for total health services indicate that wages and fringe benefits are 74.02 percent and 25.98 percent of compensation, respectively.

As in the 1996-based MEI, we are proposing to use CPS data on earnings by occupation to develop cost shares for wages for nonphysician occupational groups shown in Table 6. To arrive at a distribution for these separate categories, we multiplied the overall share for nonphysician employee wages/salaries by each of the occupational proportions from the 2000 CPS. The proposed distribution and the distribution in the current MEI are presented in Table 6.

TABLE 6.—PERCENT DISTRIBUTION OF NONPHYSICIAN PAYROLL EXPENSE BY OCCUPATIONAL GROUP: 2000 AND 1996

BLS Occupational Group	2000 Expenditure Shares	1996 Expenditure Shares
Total	100.000	100.000
Professional & Technical Workers	42.635	45.573
Managers	24.138	19.398
Clerical Workers	28.187	30.827
Service Workers	5.040	4.202

Note: Values may not sum to 100 due to rounding.

(ii) Professional Liability Expense

The weight for professional liability expense was derived from the 2003 AMA survey (2000 data) and was calculated as the mean professional liability expense expressed as a percentage of total expenses (physician earnings plus practice expenses). This calculation resulted in a 3.865 percent share of total costs in 2000 compared to a 3.152 percent share in the 1996-based index. The increase in weight for professional liability insurance represents the increases in premiums and increases in the amount of coverage purchased by physicians in 2000 compared to 1996. Since the data do not reflect any changes caused by increases in these expenses in 2001 and 2002, they do not take into account the recent acceleration in the growth in premiums that physicians have experienced and, therefore, the weights will not reflect these changes. However, the proxy that we currently use in the 1996-based index—and will continue to use in the proposed rebased and revised index—does reflect the price increases associated with the recent rise in malpractice costs.

(iii) Office, Medical Equipment, Pharmaceuticals and Medical Materials and Supplies Expenses, and All Other Expenses

The 2003 AMA survey provides less detail for expenses with respect to prior years' publications. Therefore, we calculated the share of each of the above categories by updating the AMA data for 1998 to 2000 using an appropriate price proxy. The primary reason for using the price proxy was that we lacked other data to develop cost weights for each of these categories. As stated previously, the main deficiency of this method is that it does not account for any changes in the quantity or intensity effects associated with these expenses. Our belief, however, was that it was important to continue using these detailed breakouts so that each would be proxied by an appropriate price index and that the quantity/intensity effects over a short period of time are not likely to be large. In fact, we have found that even over longer periods of time, the distribution of costs tends to be relatively similar.

Office expenses and medical equipment levels were moved to 2000 using the growth from 1998 to 2000 in their respective MEI price proxies. In the case of office expenses, we used the growth in the CPI-U Housing; for medical equipment expenses, we used the growth in the PPI for Medical Instruments and Equipment.

The share for pharmaceuticals (prescription drugs) and medical materials and supplies was calculated by separating out pharmaceuticals and other medical materials and supplies using 1997 BEA Benchmark Input-Output data. First, the sum of all the pharmaceuticals and medical supplies categories from the Benchmark Input-Output tables for 1997 was calculated. The share of pharmaceuticals and medical supplies was then calculated as a percentage of this total and applied to the 1997 AMA medical supplies data. These calculated levels were then inflated to 2000 using the growth in an appropriate price proxy. We thought it was important and appropriate to account for each of these categories separately so that differences in relative price growth between pharmaceuticals (prescription drugs) and other medical materials and supplies would be more accurately represented. The resulting 2000 data for the two separate categories were then aggregated (summed) together to form the overall total for the share for the pharmaceuticals and medical materials and supplies category in the rebased and revised MEI. The pharmaceuticals category was inflated using the Producer Price Index (PPI) for ethical prescription preparations and the medical materials and supplies category was updated using the PPI for surgical appliances and supplies.

Finally, the All Other Expense category was calculated as a residual (total expenses less the percentage of all categories currently accounted for). The additional detail for transportation expenses found in the prior MEI was removed because the data were not readily available for measurement of a cost share for 2000. The effect on the MEI of removing the detail is negligible.

4. Selection of Price Proxies for Use in the MEI

After the 2000 cost weights for the rebased and revised MEI were developed, we reviewed the current set of price proxies to determine whether they were still the most appropriate for each expenditure category. As was the case in the development of the 1996-based MEI (57 FR 55901), most of the indicators we considered are based on BLS data and are grouped into one of the following five categories:

Producer Price Indices (PPIs)

PPIs measure price changes for goods sold in other than retail markets. They are the preferred proxies for physician purchases at the wholesale level. These fixed-weight indices are a measure of price change at the producer or at the

intermediate stage of production, a more likely mode of purchase for physicians.

Consumer Price Indices (CPIs)

CPIs measure change in the prices of final goods and services purchased by consumers. Like the PPIs, they are fixed-weight. Since they may not represent the price changes faced by producers, CPIs were used if there were no appropriate PPI or if the expenditure category was similar to expenditure of retail consumers in general.

Average Hourly Earnings (AHEs)

AHEs are available for production and nonsupervisory workers for specific industries as well as for the nonfarm business economy. They are calculated by dividing gross payrolls for wages/salaries by total hours. The series reflects shifts in employment mix and, thus, is representative of actual changes in hourly earnings for industries or for the nonfarm business economy.

ECIs for Wages/Salaries

These ECIs measure the rate of change in employee wage rates per hour worked. These fixed-weight indices are not affected by shifts in industry or occupation employment levels and measure only the pure rate of change in wages.

ECIs for Employee Benefits

These ECIs measure the rate of change in employer costs of employee benefits, such as the employer's share of Social Security taxes, pension and other retirement plans, insurance benefits (life, health, disability, and accident), and paid leave. Like ECIs for wages/salaries, the ECIs for employee benefits are not affected by changes in industry output or occupational shifts.

When choosing wage and price proxies for each expense category, we evaluate the strengths and weaknesses of each proxy variable using four criteria. The first criterion is relevance. The price variable should appropriately represent price changes for specific goods or services within the expense category. Relevance may encompass judgments about relative efficiency of the market generating the price and wage increases.

The second criterion is reliability or low sampling variability. If the proxy wage-price variable has a high sampling variability or inexplicable erratic patterns over time, its value is greatly diminished, since it is unlikely to accurately reflect price changes in its associated expenditure category. Low sampling variability can conflict with relevance, since the more specifically a price variable is defined in terms of

service, commodity, or geographic area, the higher the possibility of sampling variability. The length of time the time-series data have been published is also important. A well-established time series is needed to assess the reasonableness of the series and to provide a solid base from which to forecast future price changes in the series. We need to forecast the MEI to make Federal budget and Trustees Report estimates.

The third criterion is timeliness of actual published data. For this reason, we prefer monthly and quarterly data to annual data.

The fourth criterion is public availability. We prefer to use data sources that are publicly available for our indices so that the public may track each of the individual components in the MEI.

The BLS price proxy categories previously described meet the criteria of relevance, reliability and timeliness, and public availability. Below we discuss the price-wage proxies for the rebased and revised MEI (shown in Table 1).

(a) Expense Categories in the MEI

Physician Time

In the proposed revised and rebased MEI, we are using the AHE for the private nonfarm economy as the proxy for the physician wages/salaries component; this is the same price measure used in the 1996-based MEI. In our judgment, this proxy still most closely comports with Congressional intent as expressed in the Senate Finance Committee's 1972 report (S. Rept. No. 92-1230 at 191 (1972)). AHEs change in accordance with changes in the type and mix of workers.

As we discussed extensively in the November 2, 1998 final rule (63 FR 58848) and again in the December 31, 2002 final rule (67 FR 80019), we believe that the current price proxy for physicians' earnings—AHE in the nonfarm business economy—is the most appropriate proxy to use in the MEI. The AHE for the nonfarm business economy reflects the impacts of supply, demand, and economy-wide productivity for the average worker in the economy. Using this measure as the proxy for physicians' earnings captures the parity in the rate of change in wages for the average worker and for physicians. In addition, use of this proxy is consistent with the original legislative intent that the change in the physicians' earnings portion of the MEI parallel the change in general earnings for the economy. Since earnings are expressed per hour, a constant quantity

of labor input per unit of time is reflected. The use of the AHE data is also consistent with our using the BLS economy-wide multifactor productivity measures since economy-wide wage increases reflect economy-wide productivity increases.

Using the ECI for professional and technical workers or other occupational-specific wage proxies has a major shortcoming; in many instances, occupations such as engineering, computer science, and nursing have unique characteristics that are not representative of the overall economy or the physician market. Specifically, wage changes for such occupations can be influenced by excess supply or demand for these types of workers. We believe it would not be appropriate to proxy the physician earnings portion of the MEI with a wage proxy that reflects these other occupation's unique characteristics.

The current MEI uses the ECI for fringe benefits for total private industry as the price proxy for physician fringe benefits. We are proposing to use the same proxy for the 2000-based MEI. This means that both the wage and fringe benefit proxies for physician earnings are derived from the nonfarm private sector and are computed on a per-hour basis.

Nonphysician Employee Compensation

As in the 1996-based MEI, we are proposing to use Current Population Survey data on earnings and employment by occupation to develop labor cost shares for the nonphysician occupational groups shown in Table 6. BLS maintains an ECI for each occupational group, and we propose to use these ECIs as price proxies for nonphysician employee wages in the same manner they are used in the current MEI.

The skill mix shift in employees of physician offices in the last few years has been towards managerial occupations. While these skill mix shifts are captured in the expenditure weights, they are appropriately held constant in a Laspeyres price index such as the MEI. Skill mix shifts, which may reflect the changing intensity of services provided in physicians' offices, are accounted for in the payment system outside of the MEI.

The current MEI uses the ECI for fringe benefits for white collar employees in the private sector as a proxy for nonphysician benefits. Since most nonphysician employees in physicians' offices are white-collar employees, we are again proposing to use the ECI for benefits for white collar

employees in the proposed rebased and revised MEI.

Office Expense

Office expenses include rent or mortgage for office space, furnishings, insurance, utilities, and telephone. We are proposing the continued use of the CPI-U for housing because it is a comprehensive measure of the cost of housing, including rent, owner's equivalent rent, and the types of goods and services associated with running an office. This proxy covers about 80 percent of the population.

Pharmaceuticals and Medical Materials and Supplies

This cost category includes drugs, outside laboratory work, x-ray films, and other related services. There is not one price proxy that includes this complete mix of materials and supplies. In the absence of one index, we are proposing to separately account for pharmaceuticals and medical materials and supplies in the 2000-based MEI.

- Medical Materials and Supplies

We equally weighted two proxies together (the PPI Surgical Appliances and Supplies and the CPI-U for Medical Equipment and Supplies) since one proxy does not accurately measure the price change associated with these types of products used nor the mode of purchase used in physicians' offices. While both indexes include such items as bandages, dressings, catheters, I.V. equipment, syringes, and other general disposable medical supplies and nonprescription equipment, the indexes reflect significant differences in the mode of purchase. The PPI measures actual transaction prices at the wholesale level, the mode most likely used by physicians, while the CPI measures prices at the retail level or the final stage of production. The price movements in these two indexes can be different and we believe that it is appropriate to combine these indexes into one proxy since physicians likely use both purchasing methods when obtaining medical supplies.

- Pharmaceuticals

The PPI for ethical prescription drugs is used to proxy pharmaceutical prices in other CMS market baskets and reflects the price change associated with the average mix of pharmaceuticals purchased economy-wide. We propose to use the PPI for ethical prescription drugs, rather than the CPI for prescription drugs, because physicians generally purchase drugs directly from a wholesaler. The PPIs that we use measure price changes at the final stage of production.

Professional Liability Insurance

It is vital that the MEI accurately reflect the price changes associated with professional liability costs. Accordingly, we continue to incorporate into the MEI a price proxy that accomplishes this goal by making the maximum use of available data on professional liability premiums.

Each year, we solicit professional liability premium data for physicians from a small sample of commercial carriers. This information is not collected through a survey form, but instead is requested, on a voluntary basis, from a few national commercial carriers via letter. Generally between 5 and 8 carriers volunteer this information. While the sample size certainly does not cover the entire professional liability insurance market, we have attempted to maximize the market share in terms of both national coverage and coverage within States.

As we require for our other price proxies, the professional liability price proxy should reflect the pure price change associated with this particular cost category. Thus, it should not capture changes in the mix or level of liability coverage. To accomplish this result, we obtain premium information from commercial carriers for a fixed level of coverage, currently \$1 million per occurrence and a \$3 million annual limit. This information is collected for every State by physician specialty and risk class. Finally, the State-level, physician-specialty data are aggregated by effective premium date to compute a national total, using counts of physicians by State and specialty as provided in the AMA publication, *Physician Characteristics and Distribution in the U.S.*

The resulting data provide a quarterly time series, indexed to a base year consistent with the MEI and reflect the national trend in the average professional liability premium for a given level of coverage. From this series, quarterly and annual percent changes in professional liability insurance are estimated for inclusion in the MEI.

The most comprehensive data on professional liability costs are held by the State insurance commissioners but these data are available only with a

substantial time lag and, therefore, the data currently incorporated into the MEI are much more timely. We believe that, given the limited data available on professional liability premiums, this methodology adequately reflects the price trends facing physicians.

Medical Equipment

Medical equipment includes depreciation, leases, and rent on medical equipment. We propose to use the PPI for medical instruments and equipment as the price proxy for this category, consistent with the price proxy used in the 1996-based MEI and other CMS input price indexes.

Other Professional Expenses

This category includes the residual subcategory of other professional expenses such as accounting services, legal services, office management services, continuing education, professional association memberships, journals, professional car expenses, and other professional expenses. In the absence of one price proxy or even a group of price proxies that might reflect this heterogeneous mix of goods and services, we use the CPI-U for all items, less food and energy, consistent with the price proxy used in the 1996-based MEI. We also propose to condense the structure used in the previous 1996-based MEI because we lack the data to develop a representative weight for transportation, as discussed above. This change would result in only a negligible effect on the overall MEI over the past 8 years; the average increase differs by less than a tenth of a percentage point over that time.

(b) Productivity Adjustment to the MEI

In the December 2002 final rule, we indicated that we were changing the methodology for adjusting for productivity in the MEI. The MEI used for the 2003 physician payment update reflected changes in the 10-year moving average of private nonfarm business (economy-wide) multifactor productivity applied to the entire index; we had previously used economy-wide private nonfarm business labor productivity applied to the labor portions of the index. We will continue to use the method of adjusting for

multifactor productivity applied to the entire index in the proposed rebased and revised MEI.

As described in the December 31, 2002 final rule, we used multifactor productivity because: (1) it is theoretically more appropriate to explicitly reflect the productivity gains associated with all inputs (both labor and nonlabor); (2) the recent growth rate in economy-wide multifactor productivity appears to be more consistent with the current market conditions facing physicians; and (3) the MEI still uses economy-wide wage changes as a proxy for physician wage changes. We believe that using a 10-year moving average change in economy-wide multifactor productivity produces a stable and predictable adjustment and is consistent with the moving-average methodology used in the current 1996-based MEI. The adjustment will be based on the latest available actual historical economy-wide multifactor productivity data, as measured by BLS.

5. Results of Rebasing

Updating the MEI from a 1996 base year to a 2000 base year resulted in small changes in expense category weights. Physicians' earnings dropped slightly, from 54.5 percent of the index in 1996 to 52.5 percent in 2000. The expense shares for non-physician employee compensation, office expenses, professional liability insurance, and medical equipment all rose slightly, while expense shares for medical materials and supplies and all other expenses declined.

The rebased and revised MEI is similar in structure to the current MEI. Except for two-tenths of a percentage point difference in 2000, the annual percent change in the rebased and revised MEI was within one-tenth of a percentage point of the percent change in the 1996-based MEI each year between 1996 and 2003. Therefore, the revision and rebasing proposed in this rule, while making the expense shares more timely, has little impact on the percent changes in the MEI as a whole. Table 7 below shows the average calendar-year percent change from 1996 to 2003 for both the 1996- and 2000-based MEIs.

TABLE 7.—ANNUAL PERCENT CHANGE IN THE CURRENT AND PROPOSED REVISED AND REBASED MEDICARE ECONOMIC INDEX

Update year (A)	Proposed 2000-based MEI	Current 1996-based MEI
1996	1.7	1.8
1997	1.9	1.9

TABLE 7.—ANNUAL PERCENT CHANGE IN THE CURRENT AND PROPOSED REVISED AND REBASED MEDICARE ECONOMIC INDEX—Continued

Update year (A)	Proposed 2000-based MEI	Current 1996-based MEI
1998	2.4	2.4
1999	2.7	2.6
2000	2.9	2.7
2001	2.8	2.8
2002	3.3	3.3
2003	3.1	3.0
Avg Change 1996–2003	2.6	2.6

(A) Update year based on historical data through the second quarter of the prior calendar year. For example, the 2003 update is based on historical data through the second quarter 2002.

The forecast of the proposed rebased and revised MEI for the 2004 Physician Fee Schedule is an increase of 2.5 percent, nearly identical to the

forecasted increase using the previous 1996-based MEI. In the final rule we will incorporate historical data through the second quarter of 2003; therefore,

the current estimated increase of 2.5 percent for 2004 may differ in the final rule.

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**Table 8.—Forecasted Annual Percent Change in the Current
and Proposed Revised and Rebased Medicare Economic Index,
2004**

	Proposed 2000-Based MEI	1996-Based MEI
2004	2.5	2.4

**Table 9.—Forecasted Annual Percent Change in the Proposed Revised
and Rebased Medicare Economic Index, 2004-All Categories¹**

Cost Categories and Price Measures	2000 Weights ²	Forecasted 2004 Percent Changes
Medicare Economic Index Total, productivity adjusted	n/a	2.5
Productivity: 10-year moving average of Multifactor productivity, private nonfarm business sector	n/a	0.9
Medicare Economic Index Total, without productivity adjustment	100.0	3.4
1. Physician's Own Time ³	52.466	3.5
a. Wages and Salaries: Average Hourly Earnings, private Nonfarm	42.730	3.2
b. Fringe Benefits: Employment Cost Index, benefits, private nonfarm	9.735	5.3
2. Physician's Practice Expense ³	47.534	3.2
a. Nonphysician Employee Compensation	18.654	3.4
1. Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation	13.809	2.8

2.	Fringe Benefits: Employment Cost Index, fringe benefits, white collar	4.845	5.0
b.	Office Expense: Consumer Price Index (CPI-U), housing	12.209	2.5
c.	Drugs and Medical Materials and Supplies	4.320	3.4
1.	Medical Materials and Supplies: Producer Price Index, surgical appliances and supplies/Consumer Price Index (CPI-U), medical equipment and supplies (equally weighted)	2.011	1.3
2.	Pharmaceuticals: Producer Price Index, ethical prescription drugs	2.308	4.9
d.	Professional Liability Insurance: Professional liability insurance premiums ⁴	3.865	6.6
e.	Medical Equipment: Producer Price Index, medical instruments and equipment	2.055	1.9
f.	Other Professional Expense: Consumer Price Index (CPI-U) all items less food and energy	6.433	2.0
Notes:			
1	The rates of historical change are forecast for the 12-month period ending June 30, 2003. The forecasts are based upon the latest available Bureau of Labor Statistics data as of March 2003.		
2	The weights shown for the MEI components are the 2000 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for calendar year 2000. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2000 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.		
3	The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and Consumer Price Indexes can be found on the Bureau of Labor Statistics website- http://stats.bls.gov .		
4	Derived from a CMS survey of several major commercial insurers		
n/a	Productivity is factored into the MEI compensation categories as an adjustment to the price variables; therefore, no explicit weight exists for productivity in the MEI.		

6. Adjustments to RVUs To Match the New MEI Weights

As described in the previous section, we are proposing to rebase the MEI and establish new weights for physician

work, practice expense and malpractice. Based on 2002 Medicare utilization data, we compared the proportion of total RVUs attributable to physician work, practice expense and malpractice to the new MEI weights. We show the

proportion of total RVUs attributable to work, practice expense and malpractice and their respective proposed new MEI weights across all physicians' services in the following table:

TABLE 10

	Proposed MEI weight	2002 RVUs
Physician Work	52.466%	52.649%
Practice Expense	43.669%	44.175%
Malpractice	3.865%	3.176%

The MEI weights for physician work and practice expense are lower than the proportion of 2002 aggregate RVUS attributable to these categories. The malpractice weight within the MEI is higher than its share of total aggregate 2002 RVUs. (The 2002 shares from the Medicare utilization do not match the 1996 MEI weights because deviations occur over time based on changes in the mix of services billed by physicians and other factors).

We believe there is merit in adjusting the RVUs to match the revised MEI weights. By giving more weight to malpractice and less weight to physician work and practice expenses, Medicare's payments will better reflect each component of physician practice expenses. Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than \$20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make across-the-board adjustments to preserve budget neutrality. Therefore, if we adjust the work, practice expense and malpractice RVUs to match the new MEI weights, we are required by statute to ensure that the adjustments do not increase or decrease Medicare expenditures by more than \$20 million. To meet the requirements of the statute and ensure that aggregate pools of RVUs match the proposed new MEI weights, we considered two options. We considered making no adjustments to the physician work RVUs and adjusting only the practice expense and malpractice RVUs or adjusting all 3 categories of RVUs. We considered the first option because the medical community, in the past, has expressed interest in avoiding adjustments to physician work RVUs. However, we could only meet the requirements of section 1848(c)(2)(B)(ii)(II) if we reduced the physician fee schedule

conversion factor by an additional 0.3 percentage points in addition to the - 4.2 percent reduction we are already forecasting. We believe a small reduction to the physician work RVUs is preferable to a reducing the conversion factor by an additional 0.3 percent. For this reason, we are proposing to reduce the physician work RVUs by 0.35 percent (0.9965) and the practice expense RVUs by 1.15 percent (0.9885) and increase the malpractice RVUs by 21.7 percent (1.217) to match the rebased MEI weights. The effects of these adjustments to the RVUs are included in the RVUs shown in Addendum B of this proposed rule and, as explained previously, would not require a compensating adjustment to the conversion factor.

B. Definition of Diabetes for Diabetes Self-Management Training

Section 4105(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33, enacted on August 5, 1997) provides coverage for outpatient diabetes self-management training in outpatient settings without limiting this coverage to hospital outpatient departments. The BBA provided that the services would be provided "to an individual with diabetes." In the December 29, 2000, final rule entitled, "Expanded Coverage for Outpatient Diabetes Self-Management Training and Diabetes Outcome Measurements", (65 FR 83129) we established criteria to define "an individual with diabetes." At that time, we did not have a definition of diabetes that had been widely accepted. Therefore, we established a set of medical conditions to determine who should receive the service.

In § 410.141(d), we stated that any beneficiary who has one or more of the following medical conditions occurring within the 12-month period before the physician's order for the training would be eligible for Medicare coverage for training from an approved entity:

- New onset diabetes.
- Inadequate glycemic control as evidenced by a glycosylated hemoglobin (HbA1C) level of 8.5 percent or more on two consecutive HbA1C determinations 3 or more months apart in the year before the beneficiary begins receiving training.
 - A change in treatment regimen from no diabetes medications to any diabetes medication, or from oral diabetes medication to insulin.
 - High risk for complications based on inadequate glycemic control (documented acute episodes of severe hyperglycemia or acute severe hyperglycemia occurring in the past year during which the beneficiary needed emergency room visits or hospitalization).
 - High risk based on at least one of the following documented complications:
 - Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation;
 - Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye; and
 - Kidney complications related to diabetes, when manifested by albuminuria, without other cause, or elevated creatinine.

These requirements have been shown to be burdensome to the public and to Medicare contractors. Therefore, we are proposing that the requirements be streamlined to use the definition of diabetes that was established in a later regulation at § 410.130 and is used to determine beneficiary eligibility for Medical Nutrition Therapy when the beneficiary has a diagnosis of diabetes. The definition is:

Diabetes means diabetes mellitus consisting of two types. Type 1 is an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency. Type 2 is familial hyperglycemia that occurs primarily in adults but can also occur in children

and adolescents. It is caused by an insulin resistance whose etiology is multiple and not totally understood. Gestational diabetes is any degree of glucose intolerance with onset or first recognition during pregnancy. The diagnostic criterion for a diagnosis of diabetes for a fasting glucose intolerance test is greater than or equal to 126 mg/dL.

C. Outpatient Therapy Services Performed "Incident To" Physicians' Services—Discussion Only

In almost all settings, our policy provides that outpatient therapy services can be delivered only by physical therapists, occupational therapists, physical therapy assistants, occupational therapy assistants, and speech and language pathologists as defined by our regulations at § 484.4. While there are currently no national standards for qualifications of individuals providing outpatient therapy services incident to physicians' services, we believe that standards similar to those in § 484.4 are appropriate. Section 1862(a)(20) of the Act requires that any therapy services furnished incident to a physician's professional services must meet the standards and conditions that would apply to such therapy services if they were furnished by a therapist, with the exception of the licensing requirement.

The OIG conducted a study in March of 1994 (OEI-02-09-00590) which revealed that 78 percent of "incident to" physical therapy services did represent therapy services covered under Medicare (that is, reasonable and necessary as defined in section 1862(a)(1)(A) of the Act). The study also questioned the training of staff providing these services. Also, in 2002 we contracted for a report on the utilization of therapy services. The text of that report is available at www.cms.hhs.gov/medlearn/therapy under Research Tools for Specific Therapy Topics, DynCorp Report—Outpatient Therapy Utilization September 2002. The study found that 25 percent of the beneficiaries in 2000 were treated in the offices of physicians and nonphysician practitioners. There is currently no process to ensure the quality of the services provided in those settings.

The pending implementation of financial limitations on outpatient therapy services emphasizes the need to define the qualifications of those providing therapy services. The limited therapy services covered by Medicare must be provided by people who meet qualifications needed to render skilled services.

In order to conform to section 1862(a)(20) of the Act, we are considering adopting the existing qualification and training standards (with the exception of licensure) in § 484.4 for individuals providing therapy services independently and incident to physicians' services. We are not proposing a change at this time, but are interested in receiving comments from the public, particularly physicians and staff who would be affected, on adoption of the existing standards in § 484.4, to services of independent therapists and "incident to" services as well as alternatives that we might use to ensure that qualified staff are providing "incident to" therapy services. These comments would assist us in the development of any future proposal concerning this issue.

D. Status of Anesthesia Work and Five-Year Review

In the December 2002 final rule, we modestly increased the work of anesthesia services. These changes were based on the analysis submitted by the RUC of its review of the work of 19 high-volume anesthesia codes. The RUC had provided us with its analysis but did not furnish us with a definitive recommendation. The increase in anesthesia work resulted in an increase in the national anesthesia conversion factor. (We increased the physician work component of the anesthesia conversion factor by 2.10 percent to reflect a 9.13 percent increase in anesthesia work applied to 23 percent of anesthesia allowed charges represented by the 19 codes. We applied a 1.6 percent increase to the anesthesia CF.)

The American Society of Anesthesiologists expressed concerns about the completeness of the review of anesthesia under the five-year review, and, in February 2003, we asked the RUC to continue its review of anesthesia work values; we expected to develop a final recommendation for a change in the anesthesia CF involving all anesthesia codes. We asked that the RUC complete this analysis in 2003. The RUC is considering our request and will respond to us about what action they plan to take on this issue.

E. Payment Policies for Anesthesia Services

Currently there are different payment policies for teaching anesthesiologists and teaching certified registered nurse anesthetists (CRNAs). We are seeking comments on the appropriateness of applying the CRNA teaching/resident policy to teaching anesthesiologists.

F. Technical Correction

CPT Code 96155 (Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)).

This code describes a visit with a patient's family without the patient being present and was first included in the November 1, 2001 final rule. It was incorrectly listed as an active code for which payment could be made under the physician fee schedule. Our longstanding payment policy is that we do not pay for visits with family where the patient is not present. Payment for such visits is included in the pre- and post-service work of a visit where the patient is present. Consistent with this policy, this code is non-payable under the physician fee schedule.

IV. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

V. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

VI. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980 Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for proposed rules with economically significant effects (that is, a proposed rule that would have an annual effect on the economy of \$100 million or more in any

1 year, or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities). We have simulated the effect of the proposed changes to the practice expense RVUs described earlier. The net effect of the changes we are proposing will not materially increase or decrease Medicare expenditures for physicians' services because the statute requires that changes to RVUs cannot increase or decrease expenditures more than \$20 million. Since increases in payments resulting from RVU changes must be offset by decreases in payments for other services, the proposed practice expense changes will result in a redistribution of payments among physician specialties. The RVU changes in this proposed rule have an estimated aggregate redistributive effect of approximately \$190 million dollars. (Tables 11 and 12 which appear later in this section reflect the estimated specialty impacts.) Therefore, we are considering this proposed rule to be a major rule because it is economically significant, and, thus, we have prepared a regulatory impact analysis.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a Regulatory Flexibility Analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives and less significant adverse economic impact on the small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds.

For purposes of the RFA, physicians, nonphysicians, and suppliers are considered small businesses if they generate revenues of \$6 million or less. Approximately 95 percent of physicians (except mental health specialists) are considered to be small entities. There are about 700,000 physicians, other practitioners and medical suppliers that receive Medicare payment under the

physician fee schedule. The analysis and discussion provided in this section as well as elsewhere in this proposed rule is intended to comply with the RFA requirements.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. This proposed rule would not impose unfunded mandates on State, local, or tribal governments, or on the private sector of more than \$110 million dollars.

We have examined this proposed rule in accordance with Executive Order 13132 and have determined that this regulation would not have any significant impact on the rights, roles, or responsibilities of State, local, or tribal governments.

We have prepared the following analysis, which together with the rest of this preamble, meets all assessment requirements. It explains the rationale for, and purposes of, the rule, details the costs and benefits of the rule, analyzes alternatives, and presents the measures we propose to use to minimize the burden on small entities. As indicated elsewhere in this proposed rule, we propose to make changes to the Medicare Economic Index, refine resource-based practice based practice expense RVUs and make a variety of other minor changes to our regulations, payments or payment policy to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We provide information for each of the proposed policy changes in the relevant sections in this proposed rule. As discussed elsewhere in this proposed rule, the provisions of this proposed rule, if adopted, would only change Medicare payment rates for physician fee schedule services. While this rule would revise the definition of diabetes for the purposes of outpatient diabetes self-management training, it does not impose reporting, record-keeping and other compliance requirements. We are unaware of any relevant Federal rules that duplicate, overlap or conflict with this proposed rule. The relevant sections of this proposed rule contain a description of significant alternatives.

A. Resource-Based Practice Expense Relative Value Units

Under section 1848(c)(2) of the Act, adjustments to RVUs may not cause the amount of expenditures to differ by more than \$20 million from the amount

of expenditures that would have resulted without such adjustments. We are proposing several changes that would result in a change of expenditures that would exceed \$20 million if we made no offsetting adjustments to either the conversion factor or RVUs.

With respect to practice expense, our policy has been to meet the budget neutrality requirements in the statute by incorporating a rescaling adjustment in the practice expense methodology. That is, we estimate the aggregate number of practice expense relative values that will be paid under current and proposed policy in CY 2004. We apply a uniform adjustment factor to make the aggregate number of proposed practice expense relative values equal the number estimated that would be paid under current policy.

Table 11 shows the specialty level impact on payment of changes being proposed for CY 2004. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here since physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the physician fee schedule. For instance, independent laboratories receive more than 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the physician fee schedules. The table shows only the payment impact on physician fee schedule services.

We modeled the impact of four changes to the practice expense methodology and illustrated the effect in table 11 below. The column labeled "Utilization Data" shows the effect of updating the practice expense methodology to add 2002 utilization data for codes that did not exist in the 1997–2000 period. In general, updating the methodology with the latest utilization data will have the largest impact on payment for a new service where a code was established in 2002. In some cases, the practice expense RVU will increase (for example, 64561—Implant Neuroelectrodes and 52001, Cystoscopy Removal of Clots). In other cases, they will go down (96567—photodynamic treatment skin and G0249—Providing test materials and equipment for home INR Monitoring, 77418—Radiation Treatment Delivery—Intensity Modulated Radiation). For most specialties, new codes represent a

small proportion of the specialties' revenues and updating the practice expense RVUs with utilization will have little impact on payment across all of the services the specialty provides. However, updating the practice expense methodology with the 2002 utilization data will reduce payment to radiation oncologists by approximately 1 percent. The payment reduction occurs because the practice expense RVUs for radiotherapy dose planning and radiation treatment by intensity modulated radiation are going down. Because this service represents 8 percent of Medicare revenues to radiation oncology in 2002, there is a somewhat larger impact on this specialty than will generally occur for most specialties.

The column labeled "Practice Expense Refinements" shows the impact on payment from proposed refinements to the practice expense RVUs. In general, the largest impact of

the refinements is occurring to surgical procedures with 10 and 90-day global periods. Most of the impacts on these procedures will occur because of the standardization of the intra and post period time for clinical staff. There are also modest impacts on some specialties in the non-facility practice expense RVUs from the refinements to clinical staff and medical supplies. Orthopedic surgery and hand surgery will experience an approximate reduction of 2 percent from the practice expense refinements while payments to otolaryngology will increase by nearly 2 percent. There will be more modest payment increases or decreases for all other specialties from the practice expense refinements.

The column labeled "Maxillofacial Prosthetics" shows the impact on payment from changing the specialty practice expense per hour crosswalk for oral surgery (specialty 19) and maxillofacial surgery (specialty 85) to

otolaryngology. Payments to these specialties will increase from this change and there will be virtually no impact on payment to any other specialty.

As indicated earlier, we are also adding clinical staff time to the professional component of several cardiac catheterization services increasing payments for these services by a small amount. The proposed change will cause minor payment reductions for a few other cardiology services. All other services are unaffected by this proposal. The column labeled "Professional Component of a Diagnostic Test" shows the payment impact of the proposed change.

The column labeled "Total" in table 11 below shows the payment impact by specialty of all the changes described above. If we change any of these proposals following our consideration of comments, these figures may change.

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Table 11
 Impact of Work and Practice Expense RVU Changes
 on Total Medicare Allowed Charges
 by Physician, Practitioner and Supplier Subcategory

Specialty	Medicare Allowed Charges (\$ in Millions)	Utilization Data	Practice Expense Refinements	Maxillofacial Prosthetics	Professional Component of a Diagnostic Test	Total
Physicians:						
ALLERGY/IMMUNOLOGY	\$ 156	0%	-1%	0%	0%	-1%
ANESTHESIOLOGY	\$ 1,329	0%	0%	0%	0%	0%
CARDIAC SURGERY	\$ 329	0%	0%	0%	0%	0%
CARDIOLOGY	\$ 5,860	0%	0%	0%	0%	0%
CLINICS	\$ 1,202	0%	0%	0%	0%	0%
COLON AND RECTAL SURGERY	\$ 103	0%	1%	0%	0%	1%
CRITICAL CARE	\$ 111	0%	0%	0%	0%	-1%
DERMATOLOGY	\$ 1,742	0%	0%	0%	0%	0%
EMERGENCY MEDICINE	\$ 1,462	0%	0%	0%	0%	0%
ENDOCRINOLOGY	\$ 250	0%	1%	0%	0%	1%
FAMILY PRACTICE	\$ 4,066	0%	1%	0%	0%	1%
GASTROENTEROLOGY	\$ 1,539	0%	-1%	0%	0%	-1%
GENERAL PRACTICE	\$ 966	0%	0%	0%	0%	0%
GENERAL SURGERY	\$ 2,204	0%	-1%	0%	0%	-1%
GERIATRICS	\$ 98	0%	0%	0%	0%	-1%
HAND SURGERY	\$ 47	0%	-2%	0%	0%	-2%
HEMATOLOGY/ONCOLOGY	\$ 1,107	0%	1%	0%	0%	1%
INFECTIOUS DISEASE	\$ 341	0%	0%	0%	0%	0%
INTERNAL MEDICINE	\$ 8,035	0%	1%	0%	0%	1%
INTERVENTIONAL RADIOLOGY	\$ 168	0%	0%	0%	0%	0%
NEPHROLOGY	\$ 1,209	0%	0%	0%	0%	0%
NEUROLOGY	\$ 1,088	0%	1%	0%	0%	1%
NEUROSURGERY	\$ 440	0%	0%	0%	0%	0%
OBSTETRICS/GYNECOLOGY	\$ 557	0%	0%	0%	0%	0%
OPHTHALMOLOGY	\$ 4,392	0%	-1%	0%	0%	-1%
ORTHOPEDIC SURGERY	\$ 2,686	0%	-2%	0%	0%	-2%

Specialty	Medicare Allowed Charges (\$ in Millions)	Practice Expense			Professional Component			Total
		Utilization Data	Refinements	Maxillofacial Prosthetics	Test	of a Diagnostic	Test	
OTOLARNGOLOGY	\$ 747	0%	2%	0%	0%	0%	2%	
PATHOLOGY	\$ 811	0%	0%	0%	0%	0%	0%	
PEDIATRICS	\$ 58	0%	0%	0%	0%	0%	0%	
PHYSICAL MEDICINE	\$ 601	0%	1%	0%	0%	0%	1%	
PLASTIC SURGERY	\$ 276	0%	0%	0%	0%	0%	0%	
PSYCHIATRY	\$ 1,075	0%	0%	0%	0%	0%	0%	
PULMONARY DISEASE	\$ 1,331	0%	-1%	0%	0%	0%	-1%	
RADIATION ONCOLOGY	\$ 1,019	-1%	-1%	0%	0%	0%	-3%	
RADIOLOGY	\$ 4,343	0%	0%	0%	0%	0%	0%	
RHEUMATOLOGY	\$ 358	0%	1%	0%	0%	0%	1%	
THORACIC SURGERY	\$ 460	0%	0%	0%	0%	0%	-1%	
UROLOGY	\$ 1,567	0%	0%	0%	0%	0%	2%	
VASCULAR SURGERY	\$ 446	0%	-1%	0%	0%	0%	-1%	
Practitioners:								
AUDIOLOGIST	\$ 25	0%	-1%	0%	0%	0%	-1%	
CHIROPRACTOR	\$ 596	0%	0%	0%	0%	0%	0%	
CLINICAL PSYCHOLOGIST	\$ 452	0%	0%	0%	0%	0%	0%	
CLINICAL SOCIAL WORKER	\$ 278	0%	0%	0%	0%	0%	0%	
NURSE ANESTHETIST	\$ 433	0%	0%	0%	0%	0%	0%	
NURSE PRACTITIONER	\$ 438	0%	-1%	0%	0%	0%	-1%	
OPTOMETRY	\$ 626	0%	1%	0%	0%	0%	1%	
ORAL/MAXILLOFACIAL SURGERY	\$ 33	0%	0%	8%	0%	0%	8%	
PHYSICAL/OCCUPATIONAL THERAPY	\$ 842	0%	0%	0%	0%	0%	0%	
PHYSICIANS ASSISTANT	\$ 326	0%	0%	0%	0%	0%	0%	
PODIATRY	\$ 1,319	0%	-1%	0%	0%	0%	-1%	
Suppliers:								
DIAGNOSTIC TESTING FACILITY	\$ 735	0%	-1%	0%	0%	0%	0%	
INDEPENDENT LABORATORY	\$ 517	0%	2%	0%	0%	0%	2%	
PORTABLE X-RAY SUPPLIER	\$ 82	0%	-1%	0%	0%	0%	-1%	
Other:								

Specialty	Medicare Allowed Charges (\$ in Millions)	Utilization Data	Practice Expense Refinements	Maxillofacial Prosthetics	Professional Component of a Diagnostic Test	Total
ALL OTHER	55	0%	0%	0%	0%	0%
ALL PHYSICIAN FEE SCHEDULE	61,444	0%	0%	0%	0%	0%

The statutory methodology for updating physician fee schedule conversion factor is specified in section 1848(d)(4) of the Act. Consistent with the requirements of section 1848(d)(1)(E) of the Act, we made an estimate of the physician fee schedule update for CY 2004 available to the Medicare Payment Advisory

Commission (MedPAC) and the public in March of this year. Using our point estimate of -4.2 percent, on table 12, we are showing the estimated change in average payments by specialty based on provisions of this proposed rule and the estimated physician fee schedule update. As indicated above, figures will change if we change any of our

proposals following consideration of public comment. Further, we believe it is highly likely that our estimate of the 2004 physician fee schedule update will change before we determine the final figure later this year.

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Table 12
Impact of RVU Changes
and the Physician Fee Schedule Update
by Physician, Practitioner and Supplier Subcategory

Specialty	Medicare Allowed Charges (\$ in Millions)	RVU Changes	Physician Fee Schedule Update	Total
Physicians:				
ALLERGY/IMMUNOLOGY	\$ 156	-1%	-4.2%	-5%
ANESTHESIOLOGY	\$ 1,329	0%	-4.2%	-4%
CARDIAC SURGERY	\$ 329	0%	-4.2%	-4%
CARDIOLOGY	\$ 5,860	0%	-4.2%	-4%
CLINICS	\$ 1,202	0%	-4.2%	-4%
COLON AND RECTAL SURGERY	\$ 103	1%	-4.2%	-3%
CRITICAL CARE	\$ 111	-1%	-4.2%	-5%
DERMATOLOGY	\$ 1,742	0%	-4.2%	-4%
EMERGENCY MEDICINE	\$ 1,462	0%	-4.2%	-4%
ENDOCRINOLOGY	\$ 250	1%	-4.2%	-3%
FAMILY PRACTICE	\$ 4,066	1%	-4.2%	-3%
GASTROENTEROLOGY	\$ 1,539	-1%	-4.2%	-5%
GENERAL PRACTICE	\$ 966	0%	-4.2%	-4%
GENERAL SURGERY	\$ 2,204	-1%	-4.2%	-5%
GERIATRICS	\$ 98	-1%	-4.2%	-5%
HAND SURGERY	\$ 47	-2%	-4.2%	-6%
HEMATOLOGY/ONCOLOGY	\$ 1,107	1%	-4.2%	-3%
INFECTIOUS DISEASE	\$ 341	0%	-4.2%	-4%
INTERNAL MEDICINE	\$ 8,035	1%	-4.2%	-4%
INTERVENTIONAL RADIOLOGY	\$ 168	0%	-4.2%	-4%
NEPHROLOGY	\$ 1,209	0%	-4.2%	-4%
NEUROLOGY	\$ 1,088	1%	-4.2%	-3%
NEUROSURGERY	\$ 440	0%	-4.2%	-4%
OBSTETRICS/GYNECOLOGY	\$ 557	1%	-4.2%	-4%
OPHTHALMOLOGY	\$ 4,392	-1%	-4.2%	-5%
ORTHOPEDIC SURGERY	\$ 2,686	-2%	-4.2%	-6%
OTOLARNGOLOGY	\$ 747	2%	-4.2%	-2%
PATHOLOGY	\$ 811	0%	-4.2%	-4%
PEDIATRICS	\$ 58	0%	-4.2%	-4%
PHYSICAL MEDICINE	\$ 601	1%	-4.2%	-4%
PLASTIC SURGERY	\$ 276	0%	-4.2%	-4%
PSYCHIATRY	\$ 1,075	0%	-4.2%	-4%
PULMONARY DISEASE	\$ 1,331	-1%	-4.2%	-6%
RADIATION ONCOLOGY	\$ 1,019	-3%	-4.2%	-7%
RADIOLOGY	\$ 4,343	0%	-4.2%	-4%
RHEUMATOLOGY	\$ 358	1%	-4.2%	-3%
THORACIC SURGERY	\$ 460	-1%	-4.2%	-5%
UROLOGY	\$ 1,567	2%	-4.2%	-3%
VASCULAR SURGERY	\$ 446	-1%	-4.2%	-5%

Specialty	Medicare Allowed Charges (\$ in Millions)	RVU Changes	Physician Fee Schedule Update	Total
Practitioners:				
AUDIOLOGIST	\$ 25	-1%	-4.2%	-5%
CHIROPRACTOR	\$ 596	0%	-4.2%	-4%
CLINICAL PSYCHOLOGIST	\$ 452	0%	-4.2%	-4%
CLINICAL SOCIAL WORKER	\$ 278	0%	-4.2%	-4%
NURSE ANESTHETIST	\$ 433	0%	-4.2%	-4%
NURSE PRACTITIONER	\$ 438	-1%	-4.2%	-5%
OPTOMETRY	\$ 626	1%	-4.2%	-3%
ORAL/MAXILLOFACIAL SURGERY	\$ 33	8%	-4.2%	3%
PHYSICAL/OCCUPATIONAL THERAPY	\$ 842	0%	-4.2%	-5%
PHYSICIANS ASSISTANT	\$ 326	0%	-4.2%	-4%
PODIATRY	\$ 1,319	-1%	-4.2%	-5%
Suppliers:				
DIAGNOSTIC TESTING FACILITY	\$ 735	0%	-4.2%	-5%
INDEPENDENT LABORATORY	\$ 517	2%	-4.2%	-3%
PORTABLE X-RAY SUPPLIER	\$ 82	-1%	-4.2%	-5%
Other:				
ALL OTHER	\$ 55	0%	-4.2%	-4%
ALL PHYSICIAN FEE SCHEDULE	\$ 61,444	0%	-4.2%	-4%

8/8/2003

Table 13 shows the impact on payments for selected high volume procedures of all of the changes previously discussed. This table shows the combined impact of the change in the practice expense RVUs and the estimated physician fee schedule update on total payment for the procedure.

There are separate columns that show the change in the facility rates and the non-facility rates. For an explanation of facility and non-facility practice expense refer to § 414.22(b)(5)(i). The table shows the estimated change in payment rates based on provisions of this proposed rule and the estimated

physician fee schedule update. If we change any of the provisions following the consideration of public comments, these figures may change. Further, the payment amounts shown for 2003 will change once we determine the final figure for the physician fee schedule update.

Table 13
Impact of Proposed Rule and Physician Fee Schedule Update
on Medicare Payment for Selected Procedures

HCPCS	MOD	DESC	Non-Facility			Facility		
			Old	New	% Change	Old	New	% Change
11721		Debride nail, 6 or more	\$ 37.52	\$ 35.95	-4%	\$ 29.06	\$ 27.84	-4%
17000		Destroy benign/premalignant lesion	\$ 61.43	\$ 57.44	-6%	\$ 33.11	\$ 33.48	1%
27130		Total hip arthroplasty	N/A	N/A	N/A	\$ 1,343.41	\$ 1,281.00	-5%
27236		Treat thigh fracture	N/A	N/A	N/A	\$ 1,068.99	\$ 1,019.16	-5%
27244		Treat thigh fracture	N/A	N/A	N/A	\$ 1,155.44	\$ 1,043.47	-10%
27447		Total knee arthroplasty	N/A	N/A	N/A	\$ 1,445.67	\$ 1,381.43	-4%
33533		CABG, arterial, single	N/A	N/A	N/A	\$ 1,799.18	\$ 1,733.84	-4%
35301		Rechanneling of artery	N/A	N/A	N/A	\$ 1,073.77	\$ 1,036.78	-3%
43239		Upper GI endoscopy, biopsy	\$337.69	\$308.00	-9%	\$ 155.97	\$ 149.42	-4%
45385		Lesion removal colonoscopy	\$545.53	\$475.40	-13%	\$ 290.61	\$ 271.71	-7%
66821		After cataract laser surgery	\$231.01	\$228.71	-1%	\$ 214.83	\$ 225.54	5%
66984		Cataract surg w/iol, 1 stage	N/A	N/A	N/A	\$ 672.81	\$ 650.19	-3%
67210		Treatment of retinal lesion	\$604.39	\$547.64	-9%	\$ 548.47	\$ 531.08	-3%
71010	26	Chest x-ray	\$ 9.20	\$ 8.81	-4%	\$ 9.20	\$ 8.81	-4%
71020	26	Chest x-ray	\$ 11.04	\$ 10.57	-4%	\$ 11.04	\$ 10.57	-4%
76091		Mammogram, both breasts	\$ 94.17	\$ 90.22	-4%	N/A	N/A	N/A
76091	26	Mammogram, both breasts	\$ 44.14	\$ 41.94	-5%	\$ 44.14	\$ 41.94	-5%
76092		Mammogram, screening	\$ 82.77	\$ 79.29	-4%	N/A	N/A	N/A
76092	26	Mammogram, screening	\$ 36.05	\$ 33.83	-6%	\$ 36.05	\$ 33.83	-6%
77427		Radiation tx management, x5	\$168.11	\$159.29	-5%	\$ 168.11	\$ 159.29	-5%
78465	26	Heart image (3d), multiple	\$ 75.41	\$ 71.89	-5%	\$ 75.41	\$ 71.89	-5%
88305	26	Tissue exam by pathologist	\$ 40.83	\$ 39.12	-4%	\$ 40.83	\$ 39.12	-4%
90801		Psy dx interview	\$148.98	\$143.08	-4%	\$ 140.52	\$ 134.27	-4%
90806		Psytx, off, 45-50 min	\$ 96.38	\$ 92.33	-4%	\$ 92.70	\$ 88.81	-4%
90807		Psytx, off, 45-50 min w/e&m	\$102.63	\$ 97.97	-5%	\$ 100.06	\$ 95.85	-4%
90862		Medication management	\$ 50.76	\$ 48.63	-4%	\$ 47.82	\$ 45.81	-4%
90935		Hemodialysis, one evaluation	N/A	N/A	N/A	\$ 71.36	\$ 68.37	-4%
92004		Eye exam, new patient	\$123.60	\$120.17	-3%	\$ 88.29	\$ 84.23	-5%
92012		Eye exam established patient	\$ 61.43	\$ 60.61	-1%	\$ 36.05	\$ 34.18	-5%
92014		Eye exam & treatment	\$ 91.60	\$ 89.16	-3%	\$ 58.86	\$ 56.38	-4%
92980		Insert intracoronary stent	N/A	N/A	N/A	\$ 803.03	\$ 766.13	-5%
92982		Coronary artery dilation	N/A	N/A	N/A	\$ 596.29	\$ 568.78	-5%
93000		Electrocardiogram, complete	\$ 26.12	\$ 25.37	-3%	N/A	N/A	N/A
93010		Electrocardiogram report	\$ 8.83	\$ 8.46	-4%	\$ 8.83	\$ 8.46	-4%
93015		Cardiovascular stress test	\$104.10	\$ 99.73	-4%	N/A	N/A	N/A
93307	26	Echo exam of heart	\$ 48.19	\$ 46.17	-4%	\$ 48.19	\$ 46.17	-4%
93510	26	Left heart catheterization	\$231.38	\$238.58	3%	\$ 231.38	\$ 238.58	3%
98941		Chiropractic manipulation	\$ 35.68	\$ 34.18	-4%	\$ 31.27	\$ 29.95	-4%
99202		Office/outpatient visit, new	\$ 62.54	\$ 61.32	-2%	\$ 45.98	\$ 44.05	-4%
99203		Office/outpatient visit, new	\$ 92.70	\$ 90.92	-2%	\$ 70.26	\$ 67.31	-4%
99204		Office/outpatient visit, new	\$132.06	\$128.28	-3%	\$ 103.74	\$ 99.38	-4%
99205		Office/outpatient visit, new	\$168.48	\$162.81	-3%	\$ 137.58	\$ 131.45	-4%
99211		Office/outpatient visit, est	\$ 20.60	\$ 20.79	1%	\$ 8.83	\$ 8.46	-4%
99212		Office/outpatient visit, est	\$ 36.42	\$ 36.30	0%	\$ 23.17	\$ 22.20	-4%
99213		Office/outpatient visit, est	\$ 51.13	\$ 50.04	-2%	\$ 34.58	\$ 32.77	-5%
99214		Office/outpatient visit, est	\$ 79.82	\$ 77.88	-2%	\$ 56.65	\$ 53.92	-5%
99215		Office/outpatient visit, est	\$116.98	\$113.12	-3%	\$ 91.23	\$ 87.04	-5%
99221		Initial hospital care	N/A	N/A	N/A	\$ 65.85	\$ 62.73	-5%
99222		Initial hospital care	N/A	N/A	N/A	\$ 109.25	\$ 104.66	-4%
99223		Initial hospital care	N/A	N/A	N/A	\$ 151.92	\$ 145.54	-4%
99231		Subsequent hospital care	N/A	N/A	N/A	\$ 32.74	\$ 31.36	-4%
99232		Subsequent hospital care	N/A	N/A	N/A	\$ 54.07	\$ 51.45	-5%
99233		Subsequent hospital care	N/A	N/A	N/A	\$ 76.88	\$ 73.65	-4%
99236		Observ/hosp same date	N/A	N/A	N/A	\$ 216.67	\$ 212.50	-2%
99238		Hospital discharge day	N/A	N/A	N/A	\$ 69.16	\$ 65.90	-5%

HCPCS	MOD	DESC	Non-Facility			Facility		
			Old	New	% Change	Old	New	% Change
99239		Hospital discharge day	N/A	N/A	N/A	\$ 93.80	\$ 89.51	-5%
99241		Office consultation	\$ 47.45	\$ 47.22	0%	\$ 33.11	\$ 31.72	-4%
99242		Office consultation	\$ 88.29	\$ 86.34	-2%	\$ 68.05	\$ 65.20	-4%
99243		Office consultation	\$116.61	\$114.18	-2%	\$ 90.49	\$ 86.34	-5%
99244		Office consultation	\$165.90	\$160.70	-3%	\$ 134.27	\$ 127.92	-5%
99245		Office consultation	\$215.20	\$207.57	-4%	\$ 177.67	\$ 169.86	-4%
99251		Initial inpatient consult	N/A	N/A	N/A	\$ 34.95	\$ 33.48	-4%
99252		Initial inpatient consult	N/A	N/A	N/A	\$ 70.26	\$ 67.31	-4%
99253		Initial inpatient consult	N/A	N/A	N/A	\$ 96.01	\$ 91.63	-5%
99254		Initial inpatient consult	N/A	N/A	N/A	\$ 137.95	\$ 131.80	-4%
99255		Initial inpatient consult	N/A	N/A	N/A	\$ 189.81	\$ 181.84	-4%
99261		Follow-up inpatient consult	N/A	N/A	N/A	\$ 22.07	\$ 20.79	-6%
99262		Follow-up inpatient consult	N/A	N/A	N/A	\$ 43.77	\$ 41.94	-4%
99263		Follow-up inpatient consult	N/A	N/A	N/A	\$ 65.11	\$ 62.38	-4%
99282		Emergency dept visit	N/A	N/A	N/A	\$ 26.85	\$ 25.73	-4%
99283		Emergency dept visit	N/A	N/A	N/A	\$ 60.33	\$ 57.44	-5%
99284		Emergency dept visit	N/A	N/A	N/A	\$ 94.17	\$ 89.86	-5%
99285		Emergency dept visit	N/A	N/A	N/A	\$ 146.77	\$ 140.26	-4%
99291		Critical care, first hour	\$210.05	\$230.12	10%	\$ 200.11	\$ 191.71	-4%
99292		Critical care, addl 30 min	\$107.78	\$101.85	-6%	\$ 100.06	\$ 95.85	-4%
99301		Nursing facility care	\$ 71.00	\$ 58.85	-17%	\$ 61.06	\$ 58.85	-4%
99302		Nursing facility care	\$ 96.75	\$ 79.29	-18%	\$ 81.30	\$ 79.29	-2%
99303		Nursing facility care	\$119.92	\$ 98.32	-18%	\$ 101.16	\$ 98.32	-3%
99311		Nursing fac care, subseq	\$ 40.83	\$ 32.07	-21%	\$ 30.53	\$ 32.07	5%
99312		Nursing fac care, subseq	\$ 62.54	\$ 52.86	-15%	\$ 50.40	\$ 52.86	5%
99313		Nursing fac care, subseq	\$ 85.71	\$ 72.95	-15%	\$ 71.73	\$ 72.95	2%
99348		Home visit, est patient	\$ 74.31	\$ 66.60	-10%	N/A	N/A	N/A
99350		Home visit, est patient	\$167.74	\$152.94	-9%	N/A	N/A	N/A
Gxx17		ESRD Services Age 20+, 4+ Visits/month	\$262.28	\$293.20	12%	\$ 262.28	\$ 293.20	12%
Gxx18		ESRD Services Age 20+, 2-3 Visits/month	N/A	\$109.95	N/A	N/A	\$ 109.95	N/A
Gxx19		ESRD Services Age 20+, 1 Visit/month	N/A	\$ 72.60	N/A	N/A	\$ 72.60	N/A

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B. Geographic Practice Cost Indices

As discussed in section II.B., we are proposing to revise the malpractice GPCIs based upon actual 2001 and 2002 malpractice premium data and projected 2003 malpractice premium data. Data collection is not yet complete therefore we were unable to include the proposed malpractice GPCIs in this proposed rule. The revised malpractice GPCIs in the final rule will be subject to public comment. Any changes in the GPCIs will redistribute payments among geographic areas and will not increase or decrease Medicare expenditures. Because the malpractice RVUs only represent 3.9 percent on total payments on average across all physician fee schedule services, we expect any payment impact to be modest. We will illustrate the change in the GPCIs from use of the new malpractice data in the final rule.

C. Tracking Codes

We are proposing a change in policy that will allow CMS to create national payment policy and determine national payment amounts for CPT tracking codes regardless of whether a national

coverage determination for a specific service has been made. This proposal will have no effect on Medicare expenditures but will allow for more flexibility in determining payment rates for new services.

D. Excision of Lesions

We are proposing to make the work RVUs the same for removal of benign and malignant skin lesions that have the same excised diameters that are from similar locations (for example, torso, arms, and legs). This would result in minor redistribution in payment of these services. Any impact on payment from this proposal is included in the specialty and code level impacts shown above.

E. G Codes for Monitoring Heart Rhythms

As discussed earlier, we are creating several HCPCS G codes and establishing national payment for new technology services that allow patients with cardiac arrhythmias to be monitored in a home setting. Currently, Medicare is making payment for these services under CPT code 93799, *Unlisted cardiovascular procedure or service*. Medicare carriers

make local payment determinations for unlisted procedure codes. Our proposal will have no impact on Medicare payment for these services since national payment will replace local carrier payment.

F. G Codes for Managing Dialysis Patients

As we previously discussed in section II.C., we have reviewed our current payment policy for the monthly dialysis capitation payment in response to concerns that have been raised over whether our payment policy is consistent with current medical practice. We are proposing new G codes for these services that would allow us to align the payment incentives to match the frequency of the physician personally evaluating the dialysis patient. We believe that this restructuring of payment will assist in assuring that beneficiaries with ESRD receive the highest quality dialysis care available as the proposed codes provide for reimbursement for physician involvement that is consistent with the needs of the patient in any specific month. Our proposal will not increase or decrease Medicare payments for

treatment of dialysis patients. We are decreasing our current payment to the physician for providing fewer than four visits per month. If the physician provides four or more visits per month, we are increasing our current payment.

G. Rebasings and Revising the MEI

As indicated in section III.A. of this proposed rule, we are proposing to rebase and revise the MEI for the CY 2004 physician fee schedule. Substituting the 2000 MEI weights in place of the 1996 weights currently in use will increase the MEI by approximately 0.1 percent for 2004. Based on our current estimates, we expect no impact from this proposal on any subsequent year MEI.

H. Definition of Diabetes for Diabetes Self-Management Training

We are proposing to revise the definition of diabetes for purposes of the Outpatient Diabetes Self-Management Training benefit and use the definition established to determine beneficiary eligibility for Medical Nutrition Therapy when the beneficiary has a diagnosis of diabetes. The streamlining of the beneficiary eligibility requirements for Outpatient Diabetes Self-Management Training will reduce administrative burden for the referring physician or qualified non-physician practitioner and for the accredited Outpatient Diabetes Self-Management Training programs by simplifying documentation requirements and eliminating the need for reconsiderations and appeals to clarify that the requirements have been met. As indicated in the February 28, 2003 Federal Register (68 FR 9572), we incorporated an adjustment to the SGR consistent with our original estimates of expenditures associated with this new benefit. Our experience is that expenditures have been less than originally estimated. We expect that simplifying administrative requirements associated with this new benefit will make it more likely that expenditures for diabetes self-management training will be consistent with original estimates and there will be no increase in Medicare expenditures from making these modifications.

I. Alternatives Considered

This proposed rule contains a range of policies. The preamble identifies those policies when discretion has been exercised and presents rationale for our decisions, including a presentation of nonselected options.

J. Impact on Beneficiaries

Although changes in physicians' payments were large when the

physician fee schedule was implemented in 1992, we detected no problems with beneficiary access to care. We do not believe that there would be any problem with access to care as a result of the proposed changes in this rule. While it has been suggested that the negative update for 2004 may affect beneficiary access to care, we note that the formula to determine this update is set by statute and this regulation cannot, and does not, change it. Furthermore, since beginning our transition to a resource-based practice expense system in CY 1999, we have not found that there are problems with beneficiary access to care.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 410.140 is amended by adding the definition of "Diabetes" to read as follows:

§ 410.140 Definitions.

* * * * *

Diabetes means diabetes mellitus consisting of two types. Type 1 is an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency. Type 2 is familial hyperglycemia that occurs primarily in adults but can also occur in children and adolescents. It is caused by an insulin resistance whose etiology is multiple and not totally understood. Gestational diabetes is any degree of glucose intolerance with onset or first recognition during pregnancy. The diagnostic criterion for a diagnosis of diabetes for a fasting glucose intolerance

test is greater than or equal to 126 mg/dL.

* * * * *

3. Section 410.141 is amended by adding paragraph (f) to read as follows:

§ 410.141 Outpatient diabetes self-management training.

* * * * *

(f) Beneficiaries who may be covered. Medicare Part B covers outpatient diabetes self-management training for a beneficiary who has been diagnosed with diabetes.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

2. Section 414.22(b)(6)(iii) is revised to read as follows:

§ 414.22 Relative value units.

* * * * *

(b) * * *

(6) * * *

(iii) CMS will consider for use in determining practice expense RVUs for the physician fee schedule survey data and related materials submitted to CMS by March 1, 2004 to determine CY 2005 practice expense RVUs.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 20, 2003.

Thomas A Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 22, 2003.

Tommy G. Thompson,

Secretary.

Addendum A—Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2003. Addendum B contains the RVUs for work, non-facility practice expense, facility practice expense, and malpractice expense, and other information for all services included in the physician fee schedule.

In previous years, we have listed many services in Addendum B that are not paid under the physician fee schedule. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes

and most alpha-numeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) in Addendum B.

Addendum B—2003 Relative Value Units and Related Information Used in Determining Medicare Payments for 2003

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics), and codes for anesthesiology.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier -26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code: One for the global values (both professional and technical); one for modifier -26 (PC); and one for modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier -53 is shown for a discontinued procedure. There will be RVUs for the code (CPT code 45378) with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the physician fee schedule and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the fee schedule if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national decision regarding the coverage of the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)

C = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-

by-case basis following review of documentation, such as an operative report.

D = Deleted code. These codes are deleted effective with the beginning of the calendar year.

E = Excluded from physician fee schedule by regulation. These codes are for items or services that we chose to exclude from the physician fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the physician fee schedule for these codes. Payment for them, if they are covered, continues under reasonable charge or other payment procedures.

F = Deleted/discontinued codes. Code not subject to a 90-day grace period.

G = Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services.

H = Deleted modifier. Either the TC or PC component shown for the code has been deleted, and the deleted component is shown in the data base with the H status indicator. (Code subject to a 90-day grace period.)

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Code NOT subject to a 90-day grace period.)

N = Noncovered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

P = Bundled or excluded code. There are no RVUs for these services. No separate payment should be made for them under the physician fee schedule.

— If the item or service is covered as incident to a physician's service and is furnished on the same day as a physician's service, payment for it is bundled into the payment for the physician's service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician's service).
— If the item or service is covered as other than incident to a physician's service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = Injections. There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the

physician fee schedule are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of "physicians' services" for physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2003. Codes that are not used for Medicare payment are identified with a "+."

6. *Facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for facility settings.

7. *Non-facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for non-facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2003.

9. *Facility total.* This is the sum of the work, fully implemented facility practice expense, and malpractice expense RVUs.

10. *Non-facility total.* This is the sum of the work, fully implemented non-facility practice expense, and malpractice expense RVUs.

11. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and practice expense are associated with intra service time and in some instances the post service time.)

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

¹ CPT/ ² HCPCS	MOD	Status	Description	Physician work RVUs	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non- facility total	Facility total	Global
0001T	C	Endovas repr abdo ao aneurys.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0002T	C	Endovas repr abdo ao aneurys.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0003T	C	Cervicography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0005T	C	Perc cath stent/brain cv art.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0006T	C	Perc cath stent/brain cv art.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0007T	C	Perc cath stent/brain cv art.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0008T	C	Upper gi endoscopy w/su- ture.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0009T	C	Endometrial cryoablation ..	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0010T	C	Tb test, gamma interferon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0012T	C	Osteochondral knee autograft.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0013T	C	Osteochondral knee allograft.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0014T	C	Meniscal transplant, knee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0016T	C	Thermotx choroid vasc le- sion.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0017T	C	Photocoagulat macular drusen.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0018T	C	Transcranial magnetic stimul.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T	I	Extracorp shock wave tx, ms.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0020T	C	Extracorp shock wave tx, ft.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0021T	C	Fetal oximetry, trnsvag/ cerv.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0023T	C	Phenotype drug test, hiv 1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0024T	C	Transcath cardiac reduc- tion.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0025T	C	Ultrasonic pachymetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0026T	C	Measure remnant lipoproteins.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0027T	C	Endoscopic epidural lysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0028T	C	Dexa body composition study.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0029T	C	Magnetic tx for inconti- nence.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0030T	C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0031T	C	Speculoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0032T	C	Speculoscopy w/direct sample.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0033T	C	Endovasc taa repr incl subcl.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0034T	C	Endovasc taa repr w/o subcl.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0035T	C	Insert endovasc prosth, taa.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0036T	C	Endovasc prosth, taa, add-on.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0037T	C	Artery transpose/endovas taa.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0038T	C	Rad endovasc taa rpr w/ cover.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0039T	C	Rad s/i, endovasc taa re- pair.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0040T	C	Rad s/i, endovasc taa prosth.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0041T	C	Detect ur infect agnt w/ cpas.	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

¹ CPT/ ² HCCPS	MOD	Status	Description	Physician work RVUs	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non- facility total	Facility total	Global
0042T	C	Ct perfusion w/contrast, cbf.	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0043T	C	Co expired gas analysis ...	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0044T	C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021	A	Fna w/o image	1.27	2.24	0.55	0.07	3.58	1.89	XXX
10022	A	Fna w/image	1.27	2.67	0.43	0.05	3.99	1.75	XXX
10040	A	Acne surgery	1.18	1.03	0.69	0.05	2.26	1.92	010
10060	A	Drainage of skin abscess	1.17	0.97	0.48	0.08	2.22	1.73	010
10061	A	Drainage of skin abscess	2.40	1.85	1.54	0.17	4.42	4.11	010
10080	A	Drainage of pilonidal cyst	1.17	3.11	1.17	0.09	4.37	2.43	010
10081	A	Drainage of pilonidal cyst	2.45	4.08	1.53	0.19	6.72	4.17	010
10120	A	Remove foreign body	1.22	1.50	0.42	0.10	2.82	1.74	010
10121	A	Remove foreign body	2.69	3.39	1.91	0.25	6.33	4.85	010
10140	A	Drainage of hematoma/ fluid.	1.53	1.54	0.92	0.15	3.22	2.60	010
10160	A	Puncture drainage of le- sion.	1.20	0.74	0.47	0.11	2.05	1.78	010
10180	A	Complex drainage, wound	2.25	3.28	2.10	0.25	5.78	4.60	010
11000	A	Debride infected skin	0.60	0.58	0.22	0.05	1.23	0.87	000
11001	A	Debride infected skin add- on.	0.30	0.23	0.11	0.02	0.55	0.43	ZZZ
11010	A	Debride skin, fx	4.20	6.85	2.37	0.45	11.50	7.02	010
11011	A	Debride skin/muscle, fx ...	4.95	8.17	2.41	0.53	13.65	7.89	000
11012	A	Debride skin/muscle/bone, fx.	6.88	12.07	3.93	0.89	19.84	11.70	000
11040	A	Debride skin, partial	0.50	0.54	0.21	0.05	1.09	0.76	000
11041	A	Debride skin, full	0.82	0.68	0.33	0.06	1.56	1.21	000
11042	A	Debride skin/tissue	1.12	1.01	0.47	0.09	2.22	1.68	000
11043	A	Debride tissue/muscle	2.38	3.52	2.64	0.24	6.14	5.26	010
11044	A	Debride tissue/muscle/ bone.	3.06	4.64	3.81	0.34	8.04	7.21	010
11055	R	Trim skin lesion	0.43	0.58	0.17	0.02	1.03	0.62	000
11056	R	Trim skin lesions, 2 to 4 ...	0.61	0.66	0.24	0.03	1.30	0.88	000
11057	R	Trim skin lesions, over 4 ..	0.79	0.76	0.31	0.04	1.59	1.14	000
11100	A	Biopsy of skin lesion	0.81	1.29	0.37	0.04	2.14	1.22	000
11101	A	Biopsy, skin add-on	0.41	0.34	0.19	0.02	0.77	0.62	ZZZ
11200	A	Removal of skin tags	0.77	1.08	0.78	0.04	1.89	1.59	010
11201	A	Remove skin tags add-on	0.29	0.16	0.12	0.02	0.47	0.43	ZZZ
11300	A	Shave skin lesion	0.51	1.03	0.22	0.03	1.57	0.76	000
11301	A	Shave skin lesion	0.85	1.15	0.39	0.04	2.04	1.28	000
11302	A	Shave skin lesion	1.05	1.34	0.47	0.05	2.44	1.57	000
11303	A	Shave skin lesion	1.24	1.63	0.53	0.06	2.93	1.83	000
11305	A	Shave skin lesion	0.67	0.86	0.27	0.04	1.57	0.98	000
11306	A	Shave skin lesion	0.99	1.13	0.43	0.05	2.17	1.47	000
11307	A	Shave skin lesion	1.14	1.32	0.50	0.05	2.51	1.69	000
11308	A	Shave skin lesion	1.41	1.48	0.61	0.07	2.96	2.09	000
11310	A	Shave skin lesion	0.73	1.16	0.33	0.04	1.93	1.10	000
11311	A	Shave skin lesion	1.05	1.27	0.50	0.05	2.37	1.60	000
11312	A	Shave skin lesion	1.20	1.47	0.57	0.06	2.73	1.83	000
11313	A	Shave skin lesion	1.62	1.86	0.73	0.09	3.57	2.44	000
11400	A	Exc tr-ext b9+marg 0.5 < cm.	0.93	2.10	0.94	0.06	3.09	1.93	010
11401	A	Exc tr-ext b9+marg 0.6-1 cm.	1.44	2.22	1.12	0.09	3.75	2.65	010
11402	A	Exc tr-ext b9+marg 1.1-2 cm.	1.72	2.39	1.19	0.12	4.23	3.03	010
11403	A	Exc tr-ext b9+marg 2.1-3 cm.	1.97	2.55	1.42	0.16	4.68	3.55	010
11404	A	Exc tr-ext b9+marg 3.1-4 cm.	2.21	2.86	1.48	0.18	5.25	3.87	010
11406	A	Exc tr-ext b9+marg > 4.0 cm.	3.03	3.27	1.79	0.25	6.55	5.07	010
11420	A	Exc h-f-nk-sp b9+marg 0.5 <.	1.01	1.83	0.96	0.08	2.92	2.05	010
11421	A	Exc h-f-nk-sp b9+marg 0.6-1.	1.55	2.19	1.19	0.11	3.85	2.85	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

¹ CPT/ ² HCCPCS	MOD	Status	Description	Physician work RVUs	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non- acity total	Facility total	Global
11422	A	Exc h-f-nk-sp b9+marg 1.1-2.	1.84	2.42	1.45	0.14	4.40	3.43	010
11423	A	Exc h-f-nk-sp b9+marg 2.1-3.	2.28	2.78	1.59	0.17	5.23	4.04	010
11424	A	Exc h-f-nk-sp b9+marg 3.1-4.	2.72	3.01	1.75	0.21	5.94	4.68	010
11426	A	Exc h-f-nk-sp b9+marg > 4 cm.	4.03	3.71	2.24	0.34	8.08	6.61	010
11440	A	Exc face-mm b9+marg 0.5 < cm.	1.16	2.38	1.40	0.08	3.62	2.64	010
11441	A	Exc face-mm b9+marg 0.6-1 cm.	1.89	2.64	1.72	0.11	4.64	3.72	010
11442	A	Exc face-mm b9+marg 1.1-2 cm.	2.31	2.92	1.87	0.14	5.37	4.32	010
11443	A	Exc face-mm b9+marg 2.1-3 cm.	2.86	3.30	2.11	0.18	6.34	5.15	010
11444	A	Exc face-mm b9+marg 3.1-4 cm.	3.78	3.93	2.52	0.25	7.96	6.55	010
11446	A	Exc face-mm b9+marg > 4 cm.	5.57	4.70	3.32	0.30	10.57	9.19	010
11450	A	Removal, sweat gland le- sion.	2.73	5.22	2.04	0.26	8.21	5.03	090
11451	A	Removal, sweat gland le- sion.	3.95	6.87	2.57	0.39	11.21	6.91	090
11462	A	Removal, sweat gland le- sion.	2.51	5.31	2.02	0.23	8.05	4.76	090
11463	A	Removal, sweat gland le- sion.	3.95	7.12	2.71	0.40	11.47	7.06	090
11470	A	Removal, sweat gland le- sion.	3.25	5.25	2.28	0.30	8.80	5.83	090
11471	A	Removal, sweat gland le- sion.	4.41	7.03	2.80	0.40	11.84	7.61	090
11600	A	Exc tr-ext mlg+marg 0.5 < cm.	0.93	2.58	0.84	0.09	3.60	1.86	010
11601	A	Exc tr-ext mlg+marg 0.6-1 cm.	1.44	2.63	1.10	0.12	4.19	2.66	010
11602	A	Exc tr-ext mlg+marg 1.1-2 cm.	1.72	2.82	1.20	0.13	4.67	3.05	010
11603	A	Exc tr-ext mlg+marg 2.1-3 cm.	1.97	3.08	1.27	0.16	5.21	3.40	010
11604	A	Exc tr-ext mlg+marg 3.1-4 cm.	2.21	3.41	1.35	0.18	5.80	3.74	010
11606	A	Exc tr-ext mlg+marg > 4 cm.	3.03	4.02	1.62	0.28	7.33	4.93	010
11620	A	Exc h-f-nk-sp mlg+marg 0.5 <.	1.01	2.62	0.90	0.09	3.72	2.00	010
11621	A	Exc h-f-nk-sp mlg+marg 0.6-1.	1.55	2.70	1.18	0.12	4.37	2.85	010
11622	A	Exc h-f-nk-sp mlg+marg 1.1-2.	1.84	2.95	1.31	0.15	4.94	3.30	010
11623	A	Exc h-f-nk-sp mlg+marg 2.1-3.	2.28	3.30	1.48	0.20	5.78	3.96	010
11624	A	Exc h-f-nk-sp mlg+marg 3.1-4.	2.72	3.72	1.67	0.25	6.69	4.64	010
11626	A	Exc h-f-nk-sp mlg+mar > 4 cm.	4.03	4.67	2.33	0.35	9.05	6.71	010
11640	A	Exc face-mm malig+marg 0.5 <.	1.16	2.68	1.06	0.10	3.94	2.32	010
11641	A	Exc face-mm malig+marg 0.6-1.	1.89	3.01	1.44	0.15	5.05	3.48	010
11642	A	Exc face-mm malig+marg 1.1-2.	2.31	3.39	1.63	0.18	5.88	4.12	010
11643	A	Exc face-mm malig+marg 2.1-3.	2.86	3.82	1.89	0.24	6.92	4.99	010
11644	A	Exc face-mm malig+marg 3.1-4.	3.78	4.72	2.40	0.33	8.83	6.51	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

¹ CPT/ ² HCPCS	MOD	Status	Description	Physician work RVUs	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non- facility total	Facility total	Global
11646	A	Exc face-mm mlg+marg > 4 cm.	5.57	5.76	3.38	0.46	11.79	9.41	010
11719	R	Trim nail(s)	0.17	0.25	0.07	0.01	0.43	0.25	000
11720	A	Debride nail, 1-5	0.32	0.34	0.13	0.02	0.68	0.47	000
11721	A	Debride nail, 6 or more	0.54	0.44	0.21	0.04	1.02	0.79	000
11730	A	Removal of nail plate	1.13	1.05	0.44	0.09	2.27	1.66	000
11732	A	Remove nail plate, add-on	0.57	0.45	0.23	0.05	1.07	0.85	ZZZ
11740	A	Drain blood from under nail.	0.37	0.87	0.15	0.03	1.27	0.55	000
11750	A	Removal of nail bed	1.86	2.18	1.76	0.16	4.20	3.78	010
11752	A	Remove nail bed/finger tip	2.67	2.50	1.92	0.33	5.50	4.92	010
11755	A	Biopsy, nail unit	1.31	1.12	0.56	0.06	2.49	1.93	000
11760	A	Repair of nail bed	1.58	1.88	1.24	0.17	3.63	2.99	010
11762	A	Reconstruction of nail bed	2.89	2.32	1.86	0.32	5.53	5.07	010
11765	A	Excision of nail fold, toe ...	0.69	1.18	0.53	0.05	1.92	1.27	010
11770	A	Removal of pilonidal lesion	2.61	3.50	1.53	0.24	6.35	4.38	010
11771	A	Removal of pilonidal lesion	5.74	5.80	3.35	0.56	12.10	9.65	090
11772	A	Removal of pilonidal lesion	6.98	7.34	3.91	0.68	15.00	11.57	090
11900	A	Injection into skin lesions	0.52	0.67	0.22	0.02	1.21	0.76	000
11901	A	Added skin lesions injection.	0.80	0.68	0.36	0.03	1.51	1.19	000
11920	R	Correct skin color defects	1.61	2.03	0.79	0.17	3.81	2.57	000
11921	R	Correct skin color defects	1.93	2.41	1.00	0.21	4.55	3.14	000
11922	R	Correct skin color defects	0.49	0.38	0.25	0.05	0.92	0.79	ZZZ
11950	R	Therapy for contour defects.	0.84	1.18	0.42	0.06	2.08	1.32	000
11951	R	Therapy for contour defects.	1.19	1.53	0.52	0.10	2.82	1.81	000
11952	R	Therapy for contour defects.	1.69	1.90	0.70	0.17	3.76	2.56	000
11954	R	Therapy for contour defects.	1.85	2.48	0.92	0.19	4.52	2.96	000
11960	A	Insert tissue expander(s) ..	9.08	N/A	10.74	0.88	N/A	20.70	090
11970	A	Replace tissue expander ..	7.06	N/A	6.22	0.77	N/A	14.05	090
11971	A	Remove tissue expander(s).	2.13	7.24	4.84	0.21	9.58	7.18	090
11975	N	Insert contraceptive cap ...	1.48	1.50	0.57	0.14	3.12	2.19	XXX
11976	R	Removal of contraceptive cap.	1.78	1.74	0.70	0.17	3.69	2.65	000
11977	N	Removal/reinsert contra cap.	3.30	2.42	1.28	0.31	6.03	4.89	XXX
11980	A	Implant hormone pellet(s)	1.48	1.12	0.56	0.10	2.70	2.14	000
11981	A	Insert drug implant device	1.48	1.77	0.70	0.14	3.39	2.32	XXX
11982	A	Remove drug implant device.	1.78	2.01	0.86	0.17	3.96	2.81	XXX
11983	A	Remove/insert drug implant.	3.30	2.37	1.50	0.31	5.98	5.11	XXX
12001	A	Repair superficial wound(s).	1.70	2.07	0.50	0.13	3.90	2.33	010
12002	A	Repair superficial wound(s).	1.86	2.14	0.95	0.15	4.15	2.96	010
12004	A	Repair superficial wound(s).	2.24	2.43	1.06	0.17	4.84	3.47	010
12005	A	Repair superficial wound(s).	2.86	2.94	1.25	0.23	6.03	4.34	010
12006	A	Repair superficial wound(s).	3.67	3.53	1.57	0.31	7.51	5.55	010
12007	A	Repair superficial wound(s).	4.12	3.97	1.87	0.37	8.46	6.36	010
12011	A	Repair superficial wound(s).	1.76	2.24	0.51	0.14	4.14	2.41	010
12013	A	Repair superficial wound(s).	1.99	2.39	0.99	0.16	4.54	3.14	010
12014	A	Repair superficial wound(s).	2.46	2.69	1.11	0.18	5.33	3.75	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

¹ CPT/ ² HCCPS	MOD	Status	Description	Physician work RVUs	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non- acity total	Facility total	Global
12015	A	Repair superficial wound(s).	3.19	3.28	1.31	0.24	6.71	4.74	010
12016	A	Repair superficial wound(s).	3.93	3.70	1.59	0.32	7.95	5.84	010
12017	A	Repair superficial wound(s).	4.71	N/A	1.95	0.39	N/A	7.05	010
12018	A	Repair superficial wound(s).	5.53	N/A	2.32	0.46	N/A	8.31	010
12020	A	Closure of split wound	2.62	2.74	1.77	0.24	5.60	4.63	010
12021	A	Closure of split wound	1.84	1.81	1.43	0.19	3.84	3.46	010
12031	A	Layer closure of wound(s)	2.15	2.36	0.83	0.15	4.66	3.13	010
12032	A	Layer closure of wound(s)	2.47	3.88	1.87	0.15	6.50	4.49	010
12034	A	Layer closure of wound(s)	2.92	3.24	1.44	0.21	6.37	4.57	010
12035	A	Layer closure of wound(s)	3.43	5.27	2.22	0.30	9.00	5.95	010
12036	A	Layer closure of wound(s)	4.05	5.53	2.42	0.41	9.99	6.88	010
12037	A	Layer closure of wound(s)	4.67	6.62	2.83	0.49	11.78	7.99	010
12041	A	Layer closure of wound(s)	2.37	2.53	0.88	0.17	5.07	3.42	010
12042	A	Layer closure of wound(s)	2.74	3.28	1.40	0.17	6.19	4.31	010
12044	A	Layer closure of wound(s)	3.14	3.28	1.59	0.24	6.66	4.97	010
12045	A	Layer closure of wound(s)	3.64	3.79	2.21	0.34	7.77	6.19	010
12046	A	Layer closure of wound(s)	4.25	6.61	2.82	0.40	11.26	7.47	010
12047	A	Layer closure of wound(s)	4.65	6.50	3.15	0.41	11.56	8.21	010
12051	A	Layer closure of wound(s)	2.47	3.30	1.39	0.16	5.93	4.02	010
12052	A	Layer closure of wound(s)	2.77	3.24	1.37	0.17	6.18	4.31	010
12053	A	Layer closure of wound(s)	3.12	3.29	1.53	0.20	6.61	4.85	010
12054	A	Layer closure of wound(s)	3.46	3.63	1.63	0.25	7.34	5.34	010
12055	A	Layer closure of wound(s)	4.43	4.63	2.18	0.35	9.41	6.96	010
12056	A	Layer closure of wound(s)	5.24	6.92	3.13	0.43	12.59	8.80	010
12057	A	Layer closure of wound(s)	5.96	6.27	3.84	0.50	12.73	10.30	010
13100	A	Repair of wound or lesion	3.12	3.59	1.81	0.21	6.92	5.14	010
13101	A	Repair of wound or lesion	3.92	3.83	2.26	0.22	7.97	6.40	010
13102	A	Repair wound/lesion add-on.	1.24	0.75	0.58	0.10	2.09	1.92	ZZZ
13120	A	Repair of wound or lesion	3.30	3.69	1.85	0.23	7.22	5.38	010
13121	A	Repair of wound or lesion	4.33	4.05	2.36	0.25	8.63	6.94	010
13122	A	Repair wound/lesion add-on.	1.44	0.88	0.64	0.12	2.44	2.20	ZZZ
13131	A	Repair of wound or lesion	3.79	3.96	2.18	0.25	8.00	6.22	010
13132	A	Repair of wound or lesion	5.95	4.78	3.23	0.32	11.05	9.50	010
13133	A	Repair wound/lesion add-on.	2.19	1.22	1.05	0.17	3.58	3.41	ZZZ
13150	A	Repair of wound or lesion	3.81	5.62	2.65	0.29	9.72	6.75	010
13151	A	Repair of wound or lesion	4.45	5.52	3.10	0.28	10.25	7.83	010
13152	A	Repair of wound or lesion	6.33	6.21	4.01	0.38	12.92	10.72	010
13153	A	Repair wound/lesion add-on.	2.38	1.37	1.17	0.18	3.93	3.73	ZZZ
13160	A	Late closure of wound	10.48	N/A	7.24	1.19	N/A	18.91	090
14000	A	Skin tissue rearrangement	5.89	8.69	5.21	0.46	15.04	11.56	090
14001	A	Skin tissue rearrangement	8.47	10.16	6.70	0.65	19.28	15.82	090
14020	A	Skin tissue rearrangement	6.59	9.35	6.10	0.50	16.44	13.19	090
14021	A	Skin tissue rearrangement	10.06	10.67	7.88	0.69	21.42	18.63	090
14040	A	Skin tissue rearrangement	7.87	8.44	7.01	0.55	16.86	15.43	090
14041	A	Skin tissue rearrangement	11.49	10.87	8.87	0.71	23.07	21.07	090
14060	A	Skin tissue rearrangement	8.50	9.27	7.82	0.59	18.36	16.91	090
14061	A	Skin tissue rearrangement	12.29	11.90	9.69	0.75	24.94	22.73	090
14300	A	Skin tissue rearrangement	11.76	11.41	9.32	0.88	24.05	21.96	090
14350	A	Skin tissue rearrangement	9.61	N/A	7.26	1.09	N/A	17.96	090
15000	A	Skin graft	4.00	3.89	2.24	0.37	8.26	6.61	000
15001	A	Skin graft add-on	1.00	1.39	0.42	0.11	2.50	1.53	ZZZ
15050	A	Skin pinch graft	4.30	6.08	4.81	0.46	10.84	9.57	090
15100	A	Skin split graft	9.05	12.83	7.89	0.94	22.82	17.88	090
15101	A	Skin split graft add-on	1.72	3.89	1.69	0.18	5.79	3.59	ZZZ
15120	A	Skin split graft	9.83	11.04	7.95	0.90	21.77	18.68	090
15121	A	Skin split graft add-on	2.67	4.66	1.91	0.27	7.60	4.85	ZZZ
15200	A	Skin full graft	8.03	10.93	6.11	0.73	19.69	14.87	090
15201	A	Skin full graft add-on	1.32	1.06	0.63	0.14	2.52	2.09	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

¹ CPT/ ² HCCPS	MOD	Status	Description	Physician work RVUs	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non- facility total	Facility total	Global
15220	A	Skin full graft	7.87	10.82	6.55	0.68	19.37	15.10	090
15221	A	Skin full graft add-on	1.19	0.92	0.58	0.12	2.23	1.89	ZZZ
15240	A	Skin full graft	9.04	10.38	7.80	0.80	20.22	17.64	090
15241	A	Skin full graft add-on	1.86	1.48	0.93	0.17	3.51	2.96	ZZZ
15260	A	Skin full graft	10.06	10.10	8.80	0.63	20.79	19.49	090
15261	A	Skin full graft add-on	2.23	2.78	1.45	0.17	5.18	3.85	ZZZ
15342	A	Cultured skin graft, 25 cm	1.00	1.84	0.56	0.09	2.93	1.65	010
15343	A	Culture skn graft addl 25 cm.	0.25	0.27	0.10	0.02	0.54	0.37	ZZZ
15350	A	Skin homograft	4.00	8.37	4.90	0.42	12.79	9.32	090
15351	A	Skin homograft add-on	1.00	0.95	0.40	0.11	2.06	1.51	ZZZ
15400	A	Skin heterograft	4.00	4.28	4.21	0.40	8.68	8.61	090
15401	A	Skin heterograft add-on	1.00	1.23	0.45	0.11	2.34	1.56	ZZZ
15570	A	Form skin pedicle flap	9.21	9.27	6.55	0.96	19.44	16.72	090
15572	A	Form skin pedicle flap	9.27	8.58	6.27	0.93	18.78	16.47	090
15574	A	Form skin pedicle flap	9.88	8.98	7.08	0.92	19.78	17.88	090
15576	A	Form skin pedicle flap	8.69	9.61	6.55	0.72	19.02	15.96	090
15600	A	Skin graft	1.91	7.24	2.75	0.19	9.34	4.85	090
15610	A	Skin graft	2.42	3.83	3.09	0.25	6.50	5.76	090
15620	A	Skin graft	2.94	7.64	3.75	0.28	10.86	6.97	090
15630	A	Skin graft	3.27	7.00	4.02	0.28	10.55	7.57	090
15650	A	Transfer skin pedicle flap	3.97	6.86	4.10	0.36	11.19	8.43	090
15732	A	Muscle-skin graft, head/ neck.	17.84	18.42	12.48	1.50	37.76	31.82	090
15734	A	Muscle-skin graft, trunk	17.79	18.28	12.55	1.91	37.98	32.25	090
15736	A	Muscle-skin graft, arm	16.27	18.50	11.43	1.78	36.55	29.48	090
15738	A	Muscle-skin graft, leg	17.92	18.28	11.95	1.95	38.15	31.82	090
15740	A	Island pedicle flap graft	10.25	9.97	7.91	0.62	20.84	18.78	090
15750	A	Neurovascular pedicle graft.	11.41	N/A	9.16	1.16	N/A	21.73	090
15756	A	Free myo/skin flap microvasc.	35.23	N/A	21.18	3.11	N/A	59.52	090
15757	A	Free skin flap, microvasc	35.23	N/A	22.24	3.37	N/A	60.84	090
15758	A	Free fascial flap, microvasc.	35.10	N/A	22.23	3.52	N/A	60.85	090
15760	A	Composite skin graft	8.74	9.95	7.16	0.72	19.41	16.62	090
15770	A	Derma-fat-fascia graft	7.52	N/A	6.84	0.78	N/A	15.14	090
15775	R	Hair transplant punch grafts.	3.96	2.83	1.35	0.43	7.22	5.74	000
15776	R	Hair transplant punch grafts.	5.54	5.49	2.87	0.60	11.63	9.01	000
15780	A	Abrasion treatment of skin	7.29	7.23	7.23	0.41	14.93	14.93	090
15781	A	Abrasion treatment of skin	4.85	5.46	5.46	0.27	10.58	10.58	090
15782	A	Abrasion treatment of skin	4.32	4.44	4.44	0.21	8.97	8.97	090
15783	A	Abrasion treatment of skin	4.29	5.04	4.26	0.26	9.59	8.81	090
15786	A	Abrasion, lesion, single	2.03	1.66	1.30	0.11	3.80	3.44	010
15787	A	Abrasion, lesions, add-on	0.33	0.32	0.16	0.02	0.67	0.51	ZZZ
15788	R	Chemical peel, face, epiderm.	2.09	3.39	2.24	0.11	5.59	4.44	090
15789	R	Chemical peel, face, der- mal.	4.92	6.54	5.06	0.27	11.73	10.25	090
15792	R	Chemical peel, nonfacial ..	1.86	3.22	2.82	0.10	5.18	4.78	090
15793	A	Chemical peel, nonfacial ..	3.74	N/A	4.25	0.17	N/A	8.16	090
15810	A	Salabrasion	4.74	3.99	3.99	0.42	9.15	9.15	090
15811	A	Salabrasion	5.39	6.43	5.62	0.52	12.34	11.53	090
15819	A	Plastic surgery, neck	9.38	N/A	7.36	0.77	N/A	17.51	090
15820	A	Revision of lower eyelid ...	5.15	7.01	5.48	0.30	12.46	10.93	090
15821	A	Revision of lower eyelid ...	5.72	7.40	5.64	0.31	13.43	11.67	090
15822	A	Revision of upper eyelid ...	4.45	5.93	4.45	0.22	10.60	9.12	090
15823	A	Revision of upper eyelid ...	7.05	7.93	6.35	0.32	15.30	13.72	090
15824	R	Removal of forehead wrin- kles.	0.00	0.00	0.00	0.00	0.00	0.00	000
15825	R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15826	R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15828	R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15829	R	Removal of skin wrinkles ..	0.00	0.00	0.00	0.00	0.00	0.00	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

¹ CPT/ ² HCPCS	MOD	Status	Description	Physician work RVUs	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non- facility total	Facility total	Global
15831	A	Excise excessive skin tissue.	12.40	N/A	8.36	1.30	N/A	22.06	090
15832	A	Excise excessive skin tissue.	11.59	N/A	8.52	1.21	N/A	21.32	090
15833	A	Excise excessive skin tissue.	10.64	N/A	8.22	1.17	N/A	20.03	090
15834	A	Excise excessive skin tissue.	10.85	N/A	7.80	1.18	N/A	19.83	090
15835	A	Excise excessive skin tissue.	11.67	11.70	7.76	1.13	24.50	20.56	090
15836	A	Excise excessive skin tissue.	9.34	N/A	6.92	0.95	N/A	17.21	090
15837	A	Excise excessive skin tissue.	8.43	8.10	7.12	0.78	17.31	16.33	090
15838	A	Excise excessive skin tissue.	7.13	N/A	6.23	0.58	N/A	13.94	090
15839	A	Excise excessive skin tissue.	9.38	8.02	6.31	0.88	18.28	16.57	090
15840	A	Graft for face nerve palsy	13.26	N/A	10.32	1.15	N/A	24.73	090
15841	A	Graft for face nerve palsy	23.26	N/A	15.38	2.65	N/A	41.29	090
15842	A	Flap for face nerve palsy ..	37.96	N/A	23.49	3.99	N/A	65.44	090
15845	A	Skin and muscle repair, face.	12.57	N/A	9.34	0.80	N/A	22.71	090
15850	B	Removal of sutures	0.78	1.62	0.30	0.04	2.44	1.12	XXX
15851	A	Removal of sutures	0.86	1.78	0.34	0.05	2.69	1.25	000
15852	A	Dressing change,not for burn.	0.86	1.90	0.36	0.07	2.83	1.29	000
15860	A	Test for blood flow in graft	1.95	1.30	0.80	0.13	3.38	2.88	000
15876	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15877	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15878	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15879	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15920	A	Removal of tail bone ulcer	7.95	N/A	5.68	0.83	N/A	14.46	090
15922	A	Removal of tail bone ulcer	9.90	N/A	7.50	1.06	N/A	18.46	090
15931	A	Remove sacrum pressure sore.	9.24	N/A	5.83	0.95	N/A	16.02	090
15933	A	Remove sacrum pressure sore.	10.85	N/A	8.07	1.14	N/A	20.06	090
15934	A	Remove sacrum pressure sore.	12.69	N/A	8.35	1.35	N/A	22.39	090
15935	A	Remove sacrum pressure sore.	14.57	N/A	10.51	1.56	N/A	26.64	090
15936	A	Remove sacrum pressure sore.	12.38	N/A	8.66	1.32	N/A	22.36	090
15937	A	Remove sacrum pressure sore.	14.21	N/A	10.23	1.51	N/A	25.95	090
15940	A	Remove hip pressure sore	9.34	N/A	6.33	0.98	N/A	16.65	090
15941	A	Remove hip pressure sore	11.43	N/A	9.75	1.23	N/A	22.41	090
15944	A	Remove hip pressure sore	11.46	N/A	8.87	1.21	N/A	21.54	090
15945	A	Remove hip pressure sore	12.69	N/A	9.92	1.38	N/A	23.99	090
15946	A	Remove hip pressure sore	21.57	N/A	14.86	2.32	N/A	38.75	090
15950	A	Remove thigh pressure sore.	7.54	N/A	5.54	0.80	N/A	13.88	090
15951	A	Remove thigh pressure sore.	10.72	N/A	8.08	1.14	N/A	19.94	090
15952	A	Remove thigh pressure sore.	11.39	N/A	7.81	1.19	N/A	20.39	090
15953	A	Remove thigh pressure sore.	12.63	N/A	9.22	1.38	N/A	23.23	090
15956	A	Remove thigh pressure sore.	15.52	N/A	10.96	1.64	N/A	28.12	090
15958	A	Remove thigh pressure sore.	15.48	N/A	11.24	1.66	N/A	28.38	090
15999	C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	YYY
16000	A	Initial treatment of burn(s)	0.89	0.89	0.27	0.06	1.84	1.22	000
16010	A	Treatment of burn(s)	0.87	0.68	0.65	0.07	1.62	1.59	000

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