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Department of Health and Human Services

Centers for Medicare & Medicaid Services

**42 CFR Parts 410, 414, and 485
Medicare Program; Revisions to Payment
Policies Under the Physician Fee
Schedule for Calendar Year 2003 and
Inclusion of Registered Nurses in the
Personnel Provision of the Critical Access
Hospital Emergency Services Requirement
for Frontier Areas and Remote Locations;
Final Rule**

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****42 CFR Parts 410, 414, and 485**

[CMS-1204-FC]

RIN 0938-AL21

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003 and Inclusion of Registered Nurses in the Personnel Provision of the Critical Access Hospital Emergency Services Requirement for Frontier Areas and Remote Locations**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.**ACTION:** Final rule with comment period.

SUMMARY: This final rule with comment period refines the resource-based practice expense relative value units (RVUs) and makes other changes to Medicare Part B payment policy. In addition, as required by statute, we are announcing the physician fee schedule update for CY 2003.

The update to the physician fee schedule occurs as a result of a calculation methodology specified by law. That law required the Department to set annual updates based in part on estimates of several factors. Although subsequent after-the-fact data indicate that actual increases were different to some degree from earlier estimates, the law does not permit those estimates to be revised. A subsequent law required estimates to be revised for FY 2000 and beyond.

Although we have exhaustively examined opportunities for a different interpretation of law that would allow us to correct the flaw in the formula administratively, current law does not permit such an interpretation. Accordingly, without Congressional action to address the current legal framework, the Department is compelled to announce herein a physician fee schedule update for CY 2003 of -4.4 percent.

Because the Department would adopt a change in the formula that determines the physician update if the law permitted it, we have examined how proper adjustments to past data could result in a positive update. The Department believes that revisions of estimates used to establish the sustainable growth rates (SGR) for fiscal years (FY) 1998 and 1999 and Medicare volume performance standards (MVPS) for 1990-1996 would, under present calculations, result in a positive update.

The Department intends to work closely with Congress to develop legislation that could permit a positive update, and hopes that such legislation can be passed before the negative update takes effect. Because the Department wishes to change the update promptly in the event that Congress provides the Department legal authority to do so, we are requesting comments regarding how physician fee schedule rates could and should be recalculated prospectively in the event that Congress provides the Department with legal authority to revise estimates used to establish the sustainable growth rates (SGR) and for 1998 and 1999 and the NVPS for 1990-1996.

The other policy changes concern: 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 an endoscopic base for urology codes. In addition, this rule updates the codes subject to physician self-referral prohibitions. We are expanding the definition of a screening fecal-occult blood test and are modifying our regulations to expand coverage for additional colorectal cancer screening tests through our national coverage determination process. We also make revisions to the sustainable growth rate, the anesthesia conversion factor, and the work values for some gastroenterologic services.

We are making these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services.

This final rule also clarifies the enrollment of physical and occupational therapists as therapists in private practice and clarifies the policy regarding services and supplies incident to a physician's professional services. In addition, this final rule discusses physical and occupational therapy payment caps and makes technical changes to the definition of outpatient rehabilitation services.

In addition, we are finalizing the calendar year (CY) 2002 interim RVUs and are issuing interim RVUs for new and revised procedure codes for calendar year (CY) 2003.

As required by the statute, we are announcing that the physician fee schedule update for CY 2003 is -4.4 percent, the initial estimate of the sustainable growth rate for CY 2003 is 7.6 percent, and the conversion factor for CY 2003 is \$34,592.0.

This final rule will also 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.) This policy applies if the State, following consultation with the State Boards of Medicine and Nursing, and in accordance with State law, requests that RNs be included, along with a doctor of medicine or osteopathy, a physician's assistant, or a nurse practitioner with training or experience in emergency care, as personnel authorized to provide emergency services in CAHs in frontier areas or remote locations.

DATES: *Effective date:* This rule is effective on March 1, 2003.

Comment date: We will consider comments on the definition of a screening fecal-occult blood test, the critical access hospital emergency services requirement, the physician self-referral designated health services identified in Table 10, the interim work RVUs for selected procedure codes identified in Addendum C, the practice expense direct cost inputs, and on how physician fee schedule rates could and should be recalculated prospectively in the event that Congress provides the Department with legal authority to revise estimates used to establish SGRs for 1998 and 1999 and the MVPS for 1990-1996, if we receive them at the appropriate address, as provided in the addresses section, no later than 5 p.m. on March 3, 2003.

ADDRESSES: In commenting, please refer to file code CMS-1204-FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. 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-1204-FC, 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 21244-8013.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are

encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available if you wish to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.)

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:

Marc Hartstein, (410) 786-4539, or Stephanie Monroe (410) 786-6864 (for issues related to resource-based practice expense relative value units).

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

Marc Hartstein, (410) 786-4539 (for issues related to the sustainable growth rate).

Gail Addis, (410) 786-4522 (for issues related to PET scans).

Craig Dobyski, (410) 786-4584 (for issues related to telehealth).

Terri Harris, (410) 786-6830 or Pam West, (410) 786-2302 (for issues related to physical and occupational therapy).

William Larson, (410) 786-4639 (for issues related to fecal-occult blood test).

Regina Walker-Wren, (410) 786-9160 (for issues related to clinical nurse specialists).

Dorothy Shannon, (410) 786-3396 (for issues related to services and supplies incident to a physician's professional services).

Joanne Sinsheimer, (410) 786-4620 (for issues related to updates to the list of certain services subject to the physician self-referral prohibitions).

Mary Collins, (410) 786-3189 (for issues related to the critical access hospital emergency services requirement).

Diane Milstead, (410) 786-1101 (for all other issues).

SUPPLEMENTARY INFORMATION: Inspection of Public Comments: Comments received timely will be available for public inspection as they are recorded and processed, generally beginning approximately 4 weeks after the publication of the 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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This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access*, a service of the U.S. Government Printing Office. The Web site address is: <http://www.access.gpo.gov/nara/index.html>.

Information on the physician fee schedule can be found on our homepage. You can access this data by using the following directions:

1. Go to the CMS homepage (<http://www.cms.hhs.gov>).
2. Click on "Medicare."
3. Select Medicare Payment Systems.
4. Select Physician Fee Schedule.

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 XIII.

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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
CAH	Critical Access Hospitals
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]
GPEP	Clinical Practice Expert Panel
CRNA	Certified Registered Nurse Anesthetist
E/M	Evaluation and management
GPCI	Geographic practice cost index
HCPCS	Healthcare Common Procedure Coding System
HHHA	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
MSA	Metropolitan Statistical Area
NCD	National Coverage Decision
PC	Professional Component
PEAC	Practice Expense Advisory Committee
PET	Positron Emission Tomography
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 preserve budget neutrality.

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 revised the policy for—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. These revisions ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services.

The Medicare, Medicaid, and State Child Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554) (BIPA) modernized the mammography screening benefit and authorized payment under the physician fee schedule effective January 1, 2002. It provided for biennial screening pelvic examinations for certain beneficiaries and expanded coverage for screening colonoscopies to all beneficiaries

effective July 1, 2001. It provided for annual glaucoma screenings for high-risk beneficiaries and established coverage for medical nutrition therapy services for certain beneficiaries effective January 1, 2002. It expanded payment for telehealth services effective October 1, 2001; required certain Indian Health Service providers to be paid for some services under the physician fee schedule effective July 1, 2001; and revised the payment for certain physician pathology services effective January 1, 2001. This final rule conformed our regulations to reflect these statutory provisions.

The final rule also announced the calendar year 2002 physician fee schedule conversion factor (CF) of \$36.1992.

C. Components of the Fee Schedule Payment Amounts

Under the formula set forth in section 1848(b)(1) of the Act, the payment amount for each service paid under the physician fee schedule is the product of three factors—(1) A nationally uniform relative value for the service; (2) a geographic adjustment factor (GAF) for each physician fee schedule area; and (3) a nationally uniform conversion factor (CF) for the service. The CF converts the relative values into payment amounts.

For each physician fee schedule service, there are three relative values—(1) An RVU for physician work; (2) an RVU for practice expense; and (3) an RVU for malpractice expense. For each of these components of the fee schedule, there is a geographic practice cost index (GPCI) for each fee schedule area. The GPICs reflect the relative costs of practice expenses, malpractice insurance, and physician work in an area compared to the national average for each component.

The general formula for calculating the Medicare fee schedule amount for a given service in a given fee schedule area can be expressed as:

$$\text{Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU practice expense} \times \text{GPCI practice expense}) + (\text{RVU malpractice} \times \text{GPCI malpractice})] \times \text{CF}$$

The CF for calendar year (CY) 2003 appears in section VIII. The RVUs for CY 2003 are in Addendum B. The GPICs for CY 2003 can be found in Addendum D.

Section 1848(e) of the Act requires us to develop GAFs for all physician fee schedule areas. The total GAF for a fee schedule area is equal to a weighted average of the individual GPICs for each of the three components of the service. In accordance with the statute, however,

the GAF for the physician's work reflects one-quarter of the relative cost of physician's work compared to the national average.

D. Development of the Relative Value System

1. Work Relative Value Units

Approximately 7,500 codes represent services included in the physician fee schedule. The work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original work RVUs for most codes in a cooperative agreement with us. In constructing the vignettes for the original RVUs, Harvard worked with expert panels of physicians and obtained input from physicians from numerous specialties.

The RVUs for radiology services were based on the American College of Radiology (ACR) relative value scale, which we integrated into the overall physician fee schedule. The RVUs for anesthesia services were based on RVUs from a uniform relative value guide. We established a separate CF for anesthesia services, and we continue to recognize time as a factor in determining payment for these services. As a result, there is a separate payment system for anesthesia services.

2. Practice Expense and Malpractice Expense Relative Value Units

Section 1848(c)(2)(C) of the Act required that the practice expense and malpractice expense RVUs equal the product of the base allowed charges and the practice expense and malpractice percentages for the service. Base allowed charges are defined as the national average allowed charges for the service furnished during 1991, as estimated using the most recent data available. For most services, we used 1989 charge data aged to reflect the 1991 payment rules, since those were the most recent data available for the 1992 fee schedule.

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 service. As amended by the BBA, section 1848(c) required the new payment methodology to be phased in over 4 years, effective for services furnished in 1999, with resource-based practice expense RVUs becoming fully effective in 2002. The BBA also required us to implement resource-based

malpractice RVUs for services furnished beginning in 2000.

E. Delay in the Effective Date

On November 5, 2002 we published a notice (67 FR 67319), delaying the publication of this final rule due to concerns about the data used to establish the physician fees and the need to further assess the accuracy of the data. We have concluded our review and are moving forward with our proposals unless otherwise indicated in this preamble. This rule is effective on March 3, 2003.

II. Specific Provisions for Calendar Year 2003

In response to the publication of the June 28, 2002 proposed rule, (67 FR 43846), and the interim final rule, (67 FR 43555), we received approximately 236 comments. We received comments from individual physicians, health care workers, and professional associations and societies. The majority of comments addressed the proposals related to the enrollment of therapists, anesthesia services and the SGR.

The proposed rule discussed policies that affected the number of RVUs on which payment for certain services would be based. Certain changes implemented through this final rule are subject to the \$20 million limitation on annual adjustments contained in section 1848(c)(2)(B)(ii)(II) of the Act.

After reviewing the comments and determining the policies we would implement, we have estimated the costs and savings of these policies and added those costs and savings to the estimated costs associated with any other changes in RVUs for 2003. We discuss in detail the effects of these changes in the Regulatory Impact Analysis in section XIII.

For the convenience of the reader, the headings for the policy issues correspond to the headings used in the June 28, 2002 proposed rule. More detailed background information for each issue can be found in the June 2002 interim final rule with comment period and the June 2002 proposed rule.

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, is commonly called 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. For the CY 2000 physician fee schedule, we also used data from a survey submitted by the Society of Thoracic Surgeons (STS) in calculating thoracic and cardiac surgeons' practice expenses per hour. (Please see the November 1999 final rule (64 FR 59391) for additional information concerning acceptance of these data.) For 2001, we used these STS data, as well as survey data submitted by the American Society of Vascular Surgery and the Society of Vascular Surgery. (Please see the November 2000 final rule (65 FR 65385) for additional information on the acceptance of these data.)

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 those services with a technical and professional component), 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. 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.

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

Comment: We received several comments objecting to our policy of cross-walking all utilization for therapy services in the CPT 97000 series to the physical and occupational therapy practice expense pool. One commenter stated that we are currently employing an arbitrary utilization crosswalk methodology to determine the resource-based practice expense RVUs for physical and occupational therapy. Commenters also indicated that this departure from the standard methodology has not been previously published for review and comment. In addition, one commenter challenged our assumption that most therapy services billed by physicians are furnished by therapists and stated that it is neither supported by explanatory text nor accompanying data. The commenter

indicates that if we did not employ this assumption to change the resource-based practice expense methodology only for therapy services, payments for these services would be as much as 18 percent higher. Other commenters stated that use of the "altered methodology" has resulted in inappropriate reductions in payments for physical and occupational therapy services. One commenter expressed concern that the adjustment affects SNFs, home health agencies, outpatient hospital departments and CORFs in addition to therapists in private practice. Other commenters also objected to use of a crosswalk for physical and occupational therapy services stating that the policy is inconsistent with the "top-down" methodology that bases the final RVUs for a service on a weighted average of the practice expenses of the specialties that bill Medicare. Another commenter indicated that there is no evidence to suggest that practice expenses for therapy services provided by physicians are any different from the practice expenses of all other services they provide. This commenter indicated that physician specialties were also disadvantaged because all therapy services that a specialty billed were not included in calculating the practice expense pool for that specialty, thus decreasing the dollars that could be allocated to the services performed by that specialty. The commenters strongly recommended that we discontinue use of the crosswalk and employ the standard top down methodology for computing the 2003 PERVUs for the 97000 CPT code series.

Response: We carefully reviewed comments on this issue. As indicated in our proposed rule, we do not believe that physicians provide most therapy services that are billed by physicians. We believe that the practice expenses for therapy services provided in physicians' offices by therapists are more likely to be comparable to those of therapists than physicians. For this reason, we crosswalked utilization for the therapy codes (CPT codes 97010 through 97750) to the physical and occupational therapy practice cost pools. We used the physician utilization data for the therapy evaluation codes (CPT codes 97001 through 97004) since we believe these services would be much more likely to be performed by the billing physician. In the meantime, we welcome further public comments on this issue. We note that physical therapy was the only specialty for which we used their supplemental survey data (as noted below). Use of

such survey data increases payments for physical therapy by 2 percent.

3. Practice Expense Provisions for Calendar Year 2003

a. Supplemental Practice Expense Surveys Criteria for Acceptance of Supplemental Practice Expense Surveys From the June 28, 2002 Interim Final Rule with Comment Period

On June 28, 2002 we published an interim final rule with comment period (67 FR 43555) in the **Federal Register**, which made revisions to the criteria that we apply to supplemental survey information supplied by physician, non-physician, and supplier groups for use in determining practice expense RVUs under the physician fee schedule. While this rule was effective upon publication, we provided a comment period on the revision to the criteria and are responding to the comments received in this final rule.

The following criteria had been in effect:

- Physician groups must draw their sample from the AMA Physician Masterfile to ensure a nationally representative sample that includes both members and non-members of a physician specialty group. Physician groups must arrange for the AMA to send the sample directly to their survey contractor to ensure confidentiality of the sample; that is, to ensure comparability in the methods and data collected, specialties must not know the names of the specific individuals in the sample.

- Non-physician specialties not included in the AMA's SMS must develop a method to draw a nationally representative sample of members and non-members. At a minimum, these groups must include former members in their survey sample. The sample must be drawn by the non-physician group's survey contractor, or another independent party, in a way that ensures the confidentiality of the sample; that is, to ensure comparability in the methods and data collected, specialties must not know the names of the specific individuals in the sample.

- A group (or its contractors) must conduct the survey based on the SMS survey instruments and protocols, including administration and follow-up efforts and definitions of practice expense and hours of direct patient care. In addition, any cover letters or other information furnished to survey sample participants must be comparable to the information previously supplied by the SMS contractor to its sample participants.

- Physician groups must use a contractor that has experience with the SMS or a survey firm with experience successfully conducting national multi-specialty surveys of physicians using nationally representative random samples.

- Physician groups or their contractors must submit raw survey data to us, including all complete and incomplete survey responses as well as any cover letters and instructions that accompanied the survey, by August 1, 2002 for data analysis and editing to ensure consistency. All personal identifiers in the raw data must be eliminated.

- The physician practice expense data from surveys that we use in our code-level practice expense calculations are the practice expenses per physician hour in the six practice expense categories—clinical labor, medical supplies, medical equipment, administrative labor, office overhead, and other. Supplemental survey data must include data for these categories.

In addition to the above survey criteria, we required a 90-percent confidence interval with a range of plus or minus 10 percent of the mean (that is, 1.645 times the standard error of the mean, divided by the mean should be equal to or less than 10 percent of the mean).

Based on a review of these criteria and concern that the this language had created confusion, in the June 2002 interim final rule we revised this language to indicate that we will accept surveys that achieve a sampling error of 0.15 or less at a confidence level of 90 percent. We noted that this change refines both the measurement of precision and the level of precision we will accept and could result in our acceptance of more surveys than the past criteria. In addition, we stated that we would allow specialties that have submitted surveys previously rejected under the present criteria to resubmit these surveys to be evaluated under the revised criterion.

We also amended § 414.22(b)(6) to reflect the 2-year extension in the deadline for submitting supplemental data. Specifically, we will accept supplemental data that meet the established criteria that we received by August 1, 2002 to determine CY 2003 practice expense RVUs and by August 1, 2003 to determine CY 2004 practice expense RVUs.

Comment: We received comments from several specialty organizations on the change in the precision criteria for supplemental surveys. Specialty organizations representing audiologists, physical therapists and radiologists

expressed support for the revised precision criterion. The American Academy of Audiology indicated that the revised rule makes it easier for specialty groups to submit information for our consideration. The American College of Radiology (ACR) supported the proposed change by suggesting that the previous requirements were not reasonable. The ACR indicated that radiology and radiation oncology did not conduct surveys previously because of concerns about the strictness of the original criteria. The ACR also indicated concerns about averaging the supplemental survey data with existing SMS survey data and the requirement that the survey sample would have to be selected from the AMA Masterfile. According to the ACR, the AMA Masterfile does not adequately represent radiologists and radiation oncologists that own and operate their own centers and equipment. The American Physical Therapy Association (APTA) supported the new criterion and our decision to allow previously completed surveys to be resubmitted and considered using the new precision standard. The American Society Clinical Oncology (ASCO) objected to the use of any precision criteria and outlined a number of reasons why they opposed the use of this test. The ASCO indicated that there may be wide variation in oncology practice patterns (for example, hospital based versus non-hospital based, or differentials in provision of chemotherapy) that could lead to wide variation in practice expenses among surveyed practices. They suggested that "at least in the case of oncologists, a survey that is conducted in accordance with the CMS rules should not be excluded from consideration because of failure to meet the precision criteria."

Response: If the data from physician and practitioner surveys is to be used as the basis for physician payment, it is necessary that we have assurance that the survey is both representative and reliable. Applying numerical criteria for the statistical concepts of confidence and precision give some basis for believing that the data accurately represent practice costs for the specialty nationwide. We set the criteria for precision and confidence after lengthy consultation with our contractor, the Lewin Group, and agency experts on statistical surveys. We believe the levels set are both fair and reasonable. In addition, as indicated in the proposed rule, we are attempting to be as flexible as possible consistent with our goal of obtaining new surveys of practice expense that are scientifically sound and methodologically consistent with

our existing estimates. We indicated that a specialty may include different types of physician practices that exhibit different patterns of practice expenses. We welcome stratified sampling of these different types of practices and, would, as appropriate, apply the precision criteria to subgroups of surveyed practices.

We considered the comment that suggests the AMA Masterfile may not adequately represent radiologists and radiation oncologists that own and operate their own equipment. However, since the AMA Masterfile is the most comprehensive listing of physicians that practice in the United States, we still believe it should be the best source of information for selecting a representative sample of physicians. We do acknowledge that there may be special issues related to diagnostic and radiation oncology services. For instance, radiologists and radiation oncologists that predominantly practice in hospitals may have fundamentally different practice expenses than those providing services in free-standing clinics and private offices where they likely incur far higher costs for staff, supplies, equipment and indirect costs. In addition, office-based radiologists and radiation oncologists may have substantial but irregular expenses associated with medical equipment. That is, they may purchase equipment one year and amortize the costs over several years. It is possible that modification to the survey instrument may be necessary to accurately identify annual equipment costs for some specialties. Further, independent diagnostic testing facilities also bill Medicare for diagnostic services affected by the non-physician work pool calculations. A sample of physicians selected from the AMA Masterfile is unlikely to include independent diagnostic testing facilities. We believe that all of these issues can be addressed in a supplemental survey with stratified sampling, relevant modifications to the survey instrument and augmentation of the AMA Masterfile with a listing of independent diagnostic testing facilities. As we indicated in our supplemental survey interim final rule, we are attempting to be flexible to achieve our goal of incorporating the best possible practice expense survey information into our methodology. We believe all of these issues should be considered carefully. We advise any party interested in conducting a supplemental

survey to consult the Lewin Group and us before proceeding with a survey.

Comment: We also received comments from two organizations representing emergency medicine. The Emergency Department Practice Management Association (EDPMA) is concerned that the requirement that supplemental surveys be based on the SMS survey instrument will preclude us from obtaining data on uncompensated care and emergency physician practice expenses. The EDPMA suggests that we extend the criteria to include data regarding indirect emergency medicine practice expense or uncompensated care cost. The American College of Emergency Physicians (ACEP) stated that we have failed to recognize the legitimate practice costs associated with uncompensated care pursuant to requirements imposed by the Emergency Medical Treatment and Active Labor Act (EMTALA) and that these costs should be recognized by us. Despite our acknowledgement of these costs, the commenter argues that we have not made any movement in making payment for EMTALA's uncompensated care costs.

Response: As we indicated in the November 2, 1998 final rule (63 FR 58821), we made an adjustment in the practice expense per hour for emergency medicine because of our concern that emergency medicine physicians could spend a significantly higher proportion of time than other physicians providing uncompensated care to patients. We are currently using a practice expense per hour of \$33.00 for emergency medicine. If we had not made the adjustment for uncompensated care, the practice expense per hour for emergency medicine would be \$14.90. Our adjustment assumes that 55 percent ($\$14.9 / (1 - 0.55) = \33.00) of emergency physicians' time spent treating patients is uncompensated. This has the effect of raising the practice expense per hour to reflect only the physician's time spent in revenue-generating activities. If emergency physicians believe that they spend more than 55 percent of their time treating patients for which they are not compensated, we would welcome specific data on this subject from a supplemental survey.

Comment: The American College of Cardiology (ACC) and the AMA, who wrote in support of the ACC, indicated they are aware that we would like data on practice expenses that shows the six categories of practice expenses used in the practice expense methodology.

However, the ACC indicated that the AMA no longer collects data in this disaggregated fashion and suggested that this data limitation can be overcome by simply apportioning practice expense reported in the most recent survey to the separate pools based on historical distribution patterns.

Response: We will continue to require disaggregated data from supplemental surveys because apportionment based on historical distribution patterns might not reflect actual or current cost patterns. Further, to accept this data would be inconsistent with our clearly stated rule. In both the original interim final rule published on May 3, 2000 (65 FR 25666) and in the interim final rule published on June 28, 2002 (67 FR 43556), we indicated that “* * * code-level practice expense calculations are the practice expense per physician hour in the six practice expense categories—clinical labor, medical supplies, medical equipment, administrative labor, office overhead and other. Supplemental survey data must include data for these categories.”

Result of Evaluation of Comments

We are retaining the change to the precision and confidence levels for supplemental surveys to reflect a confidence level of 90 percent and a precision level of 0.15, as stated in our interim final rule.

(ii) Submission of Supplemental Surveys—We received surveys from the American Physical Therapy Association (APTA), the American Society of Clinical Oncology (ASCO), the American College of Cardiology (ACC), and the American Academy of Pediatrics (AAP). The National Association of Portable X-Ray Providers (NAPXP) also provided us with cost data for their industry. Our contractor, the Lewin Group, has evaluated the data submitted by each organization and recommends that we use the survey information from APTA. We reviewed and agree with their analysis; therefore, we are using the APTA survey to determine practice expense RVUs for CY 2003 and subsequent years. The data supplied to the Lewin Group reflects a 1999 cost year. As indicated in our June 2002 interim final rule (67 FR 43556), we are deflating the figures by the MEI to reflect a 1995 cost year. The revised practice expense per hour figures that we are using for physical therapy (specialty code 65) and occupational therapy (specialty code 67) are as follows:

TABLE 1

Clinical staff	Admin. staff	Office expense	Supplies	Equipment	Other	Total
10.4	6.5	13.4	2.4	2.2	7.7	42.5

The Lewin Group raised significant concerns about the data received from ASCO. Specifically, the Lewin Group is concerned about extraordinarily high expenses associated with clinical and clerical staff and a more than 300 percent increase in "other" practice expenses compared to the SMS value for oncology. As a result, the Lewin Group carefully examined the underlying data. They report that compensation (including salaries and fringe benefits) would average out to \$71,014 for clinical staff and \$87,253 for clerical staff. They believe it is unlikely that the average annual salary for clerical staff would be higher than for clinical staff. Further, the Lewin Group indicates that the average clerical compensation from the ASCO survey is approximately 400 percent higher than the figure reported by the Bureau of Labor Statistics for "Office Clerks, General." While the Lewin Group indicates that the high payroll expense for clinical staff may be explained, in part, by recent changes in labor markets, we remain concerned that the compensation reported in the survey is far higher than independent information on oncology nursing salaries provided to us by the Oncology Nursing Society. The Lewin Group also indicated that "other professional expenses" increased more than 349 percent from the SMS to the supplemental survey and the contribution of this category to total practice expenses increased from 9.4 percent to 22.3 percent. They believe that such a large increase in practice expense per hour needs further examination. The Lewin Group believes that we should confer with ASCO and request a rationale for the high values found in the survey results or validate the data in some other fashion. Therefore, at this time, we are not using the supplemental survey received from ASCO. However, we would like to further examine the data with the Lewin Group and discuss the survey results with ASCO and will consider using the data in the future if our concerns are addressed.

In the June 2002 proposed rule (67 FR 43850), we discussed an adjustment made to the medical supplies practice expense per hour for oncology. We made this adjustment because of a concern that the inordinately high practice expense per hour includes

expenses associated with separately billable drugs. We expressed an interest in reconsidering the adjustment consistent with a recommendation made by the GAO in their October 2001 report. If we resolve concerns about the oncology survey data, the adjustment for medical supplies will no longer be necessary since the supplemental survey collects information on medical supplies practice expenses net of separately billable drugs.

The Lewin Group indicated that the surveys from the ACC and the AAP do not meet requirements established in regulations for supplemental surveys. As a result, we will not be incorporating data from the ACC or the AAP into the practice expense methodology. We will be making the Lewin Group's full recommendations available on our website. The National Association of Portable X-ray Providers (NAPXP) did not provide us with data as part of the supplemental survey process. However, they requested that we use their data to develop practice expense RVUs for the physician fee schedule services they provide. Since we were provided with survey information, we asked the Lewin Group to evaluate the data using the same standards of review applied to other specialty survey data. The Lewin Group evaluated whether the cost information supplied by NAPXP meets our criteria for acceptance of supplemental surveys. The Lewin Group found that (1) More information is required to determine if the data are broadly representative of the portable x-ray industry and (2) the data as presented are not adequately detailed to support a practice expense per hour based on the current practice expense methodology.

Comment: Health Trac, a supplier of portable x-rays and other imaging services, commented that the practice costs associated with set-up of portable x-ray equipment are not included in the SMS and there are sufficient differences among geographic regions in the performance of this procedure that warrant reclassifying this service as carrier-priced.

Response: At this time, we are not making portable x-ray set-up (Q0092) a carrier-priced service. However, we will continue to work with the suppliers of portable x-ray services to find the best

ways of developing payment rates for these services.

b. CPEP Data

(i) 2001 PEAC/RUC

Recommendations on CPEP inputs

In the November 2001 final rule (66 FR 55256), we responded to the PEAC/RUC recommendations for the refinement to all or part of the CPEP inputs for over 1,100 codes. These included refinements of large numbers of orthopedic, dermatology, pathology, physical medicine, and ophthalmology services. In addition, these recommendations confirmed that there were no inputs for over 150 ZZZ-global procedures that are performed only in a facility and no supply or equipment inputs for almost 700 facility-only services with an XXX or 0-day global period.

We accepted almost all of the recommendations with only minor revisions. We received the following comments on our responses and modifications to the RUC recommendations on the CPEP inputs.

Comment: Specialty societies representing radiology and orthopedic surgery both expressed appreciation about our willingness to work with the RUC and PEAC on practice expense refinement, as well as for our implementation of the refinements already submitted by the PEAC. Both societies agreed with our establishment of revised practice expense values as "interim" until the refinement process is complete.

Response: We are also pleased with the progress of the refinement of the CPEP inputs and thank the PEAC, RUC and all the involved specialty societies for the hard work and dedicated commitment that has led to a successful refinement process.

Comment: A specialty society representing surgeons expressed support for our decisions on CPEP revisions in general and commended our staff for our efforts to develop appropriate and acceptable inputs for a large number of codes. The commenter also agreed with the use of the refined evaluation and management (E/M) inputs to refine post-surgical visits, but recommended that the process should allow for exceptions.

Response: We understand that the PEAC has developed a standard

approach to estimating the clinical staff time involved in post-surgical visits in which the times associated with the assigned E/M visits are applied to the post-surgical clinical staff times. It is also our understanding that, as with all the standards and packages that the PEAC has developed, a specialty would be free to argue that something other than the standard should be applied to a given service.

Comment: One commenter representing family physicians noted that we had accepted most of the practice expense recommendations submitted by the PEAC/RUC and commended us for our willingness to accept these recommendations. The commenter also suggested that the PEAC recommendations for the fine needle aspiration CPT codes 88170 and 88171, which were deleted CPT codes for 2002, should be applied to CPT codes 10021 and 10022 that replace these deleted codes.

Response: We agree with this suggestion. When CPT codes 10021 and 10022 were originally valued by the RUC, the practice expense inputs were crosswalked from the then unrefined inputs for CPT codes 88170 and 88171. Now that these inputs have been refined, it is appropriate for us to crosswalk the inputs for CPT codes 10021 and 10022 from this updated CPEP data.

Comment: A commenter representing dermatologists was pleased with our acceptance of PEAC revisions for the phototherapy codes. However, the commenter expressed concern about the decrease in the practice expense RVUs for the code for the application of an Unna boot, CPT code 29580, and for the cryotherapy code, CPT code 17340 and requested that we explain the decrease. A specialty society representing podiatrists agreed with decision to retain the Unna boot in the list of supplies for CPT code 29580.

Response: Both CPT codes 29580 and 17340 were refined by the PEAC in October 2001 and were included in the PEAC/RUC recommendations for 2002. We accepted these recommendations without change, except that we retained an Unna boot in the supply list for CPT code 29580. The recommendations contained lower direct cost inputs than the original CPEP panel data, which explains the decrease in payment for these services.

Comment: A specialty society representing urologists requested an explanation of why the bougie a boule was deleted from the equipment list for the cystourethroscopy code, CPT code 52281 and requested that it be added as a supply.

Response: Since the inception of resource-based practice expense, the supply list has been used for disposable items and we have only included as equipment those items that are more than \$500. The bougie a boule is not a disposable item, and at a cost of \$105 it does not meet the definition of equipment. These definitions have applied across the spectrum of physician fee schedule services and, therefore, we do not believe that any specialty has been disadvantaged. If we did include a \$100 item in our equipment list with a five-year expected life, it would add only \$0.0004 per minute of use to the input costs of any associated procedure and, thus, would have no effect on the practice expense RVUs for that service.

Comment: Two organizations representing physical and occupational therapists argued strongly that the revisions we made to the PEAC recommendations on the practice expense inputs for the physical medicine and rehabilitation (PM&R) codes were inappropriate. The physical therapy comment commended the specialty societies participating in the PEAC, as well as AMA and our staff, for their time and assistance as the clinical inputs for the therapy codes were developed. However, the commenter also expressed concern that we did not accept the PEAC's recommendations in their entirety despite the fact that we state in the rule that the PEAC refinement process is working. The comment from the occupational therapists shared this concern and both commenters urged us to revisit our decision and accept the PEAC recommendations for the CPT codes in the 97000 series without revisions.

Specifically, both commenters objected to the deletion of the PEAC approved clinical staff time for obtaining vital signs and measurements, patient education and phone calls. One commenter contended that our decision is contrary to the standardized times that we have allowed for physicians' clinical staff and to the survey data presented which demonstrated that clinical staff do perform these services in therapy practices. The other commenter argued that, because we have allowed such clinical staff time for other specialties, our revisions disrupt the resource-based relative value scale on which the physician fee schedule is based. Further, the occupational therapy comment states that the addition of 7 minutes only in the evaluation and reevaluation codes for aide services is insufficient to counteract the deletion of the physical therapy assistant time, and that this has created anomalies in the

practice expense RVUs within the PM&R family of services.

Response: We deleted the times assigned to the physical therapy assistant for taking vital signs, and for phone calls and patient education because we were concerned that there could be an overlap between the work of the physical therapist, which is reflected in the work RVUs, and the work of the assistant, which is considered as practice expense. However, the commenters are correct that we have allowed such tasks to be considered as practice expense for other services, even though there could also be some potential overlap between practitioner and clinical staff work. We still believe that this can be more problematic with therapy services because of the broad range of clinical activities that the physical therapy assistant can share with the therapist, but also believe that this issue might be better addressed as a general issue across all specialties. Therefore, we are revising the clinical staff times for all codes in the CPT 97000 series to reflect the 2001 PEAC recommendations for these services.

Comment: The specialty society representing physical therapy commented that the relatively high practice expense of 0.45 RVUs for CPT code 97530, therapeutic activities, cause a rank order anomaly with other codes in the CPT 97000 series. For example, therapeutic exercise (CPT code 97110) only has a PE value of 0.25. The commenter speculated that this might be due to inclusion of the environmental module in the equipment list for this code.

Response: On analyzing the differences in CPEP inputs between these two codes, it became apparent that the major contributor to the possible anomalous practice expense values lies not with the equipment for CPT code 97530, but with the supplies. For the timed codes that are billed in 15-minute increments, the PEAC recommendations generally assumed that two 15-minute sessions would be performed during one visit. Therefore, for all of these codes, including CPT code 97110, the PEAC recommendations divided the supplies by half because they would not have to be replaced for the second 15-minute session. However, inadvertently, the recommendation for the therapeutic activities code, CPT code 97530, did not make this adjustment, and the full cost of the relatively expensive woodworking kit was assigned to the code. In addition, it seems unlikely that a supply like a \$13 woodworking kit would necessarily be discarded after one visit. Therefore, we are

apportioning the cost of this kit over four sessions, and are assigning one-fourth of a kit to CPT code 97530.

Comment: The comment from the physical therapy specialty society raised the concern that there may be an inadvertent error in the printing of the values of physical therapy and occupational therapy evaluation and reevaluation CPT codes in the final rule. First, the values for the occupational therapy codes are significantly higher than values for the physical therapy codes, which did not change from the 2001 values, despite the refinement of these codes. Second, the practice expense RVUs for the occupational therapy evaluation and re-evaluation codes are the same, which appears inappropriate.

Response: The practice expense RVUs for the occupational therapy evaluation and re-evaluation codes are higher than those for physical therapy because the PEAC recommendations, which were based on the specialty societies' presentation and which we later accepted, assigned higher cost supplies and equipment to the occupational therapy codes than to the physical therapy evaluation and re-evaluation services. In addition, although the occupational therapy evaluation code had higher cost equipment than the re-evaluation code, the opposite was true for supplies. We would certainly consider information that might point to specific problems in any inputs assigned to these codes, but, at this point, have no basis for making any changes in the direct cost inputs.

Comment: A medical electronics manufacturer commented that the practice expense RVUs assigned to short wave diathermy treatment (CPT code 97024) may not take into account all of the resources required to provide the service, because the cost of the equipment alone is not covered by the practice expense reimbursement. The commenter suggested that the cost of the diathermy machine has increased greatly since 1995, when the equipment was last priced, and stated that the current price is between \$18,000 and \$30,000. The commenter urged us to reevaluate and increase the 2002 fee schedule reimbursement to ensure that diathermy continues to be available for beneficiaries.

Response: We accepted the PEAC recommendations for the direct cost inputs for CPT code 97024, except for the deletion of one minute of physical therapy assistant time. The PEAC recommendation was based on a presentation that was made by the physical therapy specialty society. The current CPEP inputs consist of 2

minutes for a physical therapy aide and 3 minutes of physical therapy assistant time and 15 minutes of a low mat table and diathermy machine. There were no supplies assigned because the supplies are included in the procedures that are typically delivered with this modality. We have seen no evidence that would indicate that any of these inputs are incorrect. Therefore, we will make no revisions to the inputs at this time. However, we have two diathermy machines in our CPEP input database. We currently have assigned the machine priced at \$2850 to the diathermy code, but will substitute the higher priced machine, which we have priced at \$3120, until we have more definitive information regarding the typical cost of the equipment. We have a contractor who is currently updating the prices of all the supplies and equipment listed in the CPEP database, and will soon be proposing updated prices for all the CPEP inputs, including the diathermy equipment.

(ii) PEAC/RUC Recommendations on CPEP Inputs for 2003

We have received recommendations from the PEAC on the refinement to the CPEP direct practice expense inputs for over 1200 codes. (A list of these codes can be found in Addendum F.) These include refinements to codes from almost every major specialty. In addition, the PEAC has continued to standardize inputs to streamline the refinement process. Previously, the PEAC created standardized inputs for 90-day global services as well as supply packages for evaluation and management, neurosurgery, gynecology services, ophthalmology and postoperative services. The PEAC has also established standard times for certain clinical staff tasks, such as greeting and gowning the patient, the taking of vital signs and post-service phone calls. These current recommendations include standardized times for office-based clinical staff for services provided during a patient's hospitalization and for discharge day management services, as well as pre-service clinical staff time data for 323 neurosurgery procedures. At an early PEAC meeting a list was drawn up of the codes most in need of refining. Of the 122 codes on this list, only seven have not yet been refined, which is one important measure of the success of the PEAC's efforts.

As stated above, we are very pleased with the progress that the PEAC has made so far and appreciate greatly the contributions that have been made to our refinement effort by the PEAC members, as well as by the staff from the

AMA and the specialty societies. We have reviewed the submitted PEAC recommendations and are also pleased that, because of the expertise gained by the PEAC in evaluating the practice expense inputs, we are able to accept all of the recommendations without any revision. The complete PEAC recommendations and the revised CPEP database can be found on our Web site. (See the **SUPPLEMENTARY INFORMATION** section of this rule for directions on accessing our Web site.)

(iii) Other Comments on the Refinement of the CPEP Inputs

Comment: We received comments from specialty societies representing vascular surgery, radiation oncology, rheumatology, physical therapy and internal medicine agreeing with the update we made to the clinical staff categories and to the revised salary data. Several of these commenters also thanked us for our analysis and use of the additional data that was supplied by the specialty societies.

Response: We appreciate the positive response to our repricing of clinical staff salaries.

Comment: The specialty society representing radiology expressed appreciation for the establishment of new clinical wage rates for CT technologist, MRI technologist, medical physicist, and dosimetrist. However, the comment expressed disagreement with our decision to merge the x-ray technician and radiation technologist staff types under the title of "radiologic technologist," because the education and scope of practice for these staff types are different and merging them will reduce the radiation technologists wage rate. The specialty society also opposed the decision to blend the staff types of RN and sonographers because they are trained to provide different services and are not interchangeable.

Response: The original CPEP data listed both "x-ray technician" and "radiation technologist" and seemingly made no distinction between these two staff types because the same wage rate was assigned to both. We used the Bureau of Labor Statistics' salary data to determine the wage rate for the "radiologic technologist." Therefore, we do not believe that the salary assigned has been reduced in any way. If some of the radiology procedures typically use staff that are paid at a lower rate than the radiologic technologist, this information should be provided by the specialty society when the practice expense inputs for the services are refined. Regarding the second concern, we did not make a decision to blend the staff types, "RN" and "diagnostic

medical sonographer." This blend currently exists in the original CPEP data and has also been contained in several PEAC recommendations. Both staff types are priced separately and we were merely listing what the pricing would be when such a blend was applied to any service.

Comment: Three specialty societies, representing surgeons, thoracic surgeons and ophthalmologists, commented on the issue of our previous exclusion from the CPEP data of all claimed time associated with staff brought to the hospital by the physician. The commenters from the surgical and the thoracic surgery specialty societies claimed that a recent report by the Office of the Inspector General (OIG) confirms that over 70 percent of cardiac surgeons bring staff to the hospital, but that only 19 percent are being reimbursed by the hospital. The commenters further argued that this is an inequitable arrangement that requires corrective action by us. The commenter from the ophthalmology society claimed that ophthalmologists bring their staff to the facility setting 50 percent of the time and some cost for this should be built into their practice expense.

Response: In the November 2, 1999 final rule (64 FR 59399), we adopted a policy to exclude all clinical staff time in the facility setting from the input data used to develop practice expense RVUs. Among other arguments, we indicated that Medicare should not pay twice for the same service. That is, Medicare's payment to the hospital includes payment for clinical staff and we should not also compensate a physician for using their own staff in the hospital. In addition, we argued that we also pay for physician-extender staff used in the facility setting, such as physician assistants and nurse practitioners, through the physician work RVUs, and we pay physician assistants directly when performing as an assistant-at-surgery. In response to this argument, thoracic surgeons contended that hospitals are no longer providing the staff to furnish adequate care. While we did not change our policy, we asked the Office of Inspector General (OIG) to conduct an independent assessment of staffing arrangements between hospitals and thoracic surgeons (see November 1, 2000 final rule 65 FR 65395). In April, 2002 (OEI-09-01-00130, page ii), OIG concluded:

Medicare pays for non-physician staff even though surgeons do not receive additional payment for some of the staff they bring to the hospital. Instead, services of these staff are paid to either physicians through the work relative value units, to the mid-level

practitioners directly, or to the hospital through Part A or the Ambulatory Payment Classification system for outpatient services. Recognizing this, some hospitals and cardiothoracic surgeons have entered into arrangements whereby hospitals provide some compensation to surgeons who bring their own staff.

We believe the OIG report clearly supports our position to exclude the costs of clinical staff brought to the hospital from the practice expense calculations. While it may be common for thoracic surgeons to bring staff to hospitals, the OIG report makes clear that Medicare pays for these costs either directly to physicians or the hospital. Since the OIG report supports our position, we are not making any revisions to our policy to exclude practice expense inputs associated with bringing clinical staff to hospitals.

Comment: One commenter representing an independent diagnostic testing facility commented that a review of the practice expense inputs for the 24-hour cardiac monitoring HCPCS codes G0005, G0006 and G0007 and the corresponding CPT codes 93270, 93271, and 93272 revealed the CPEP input lists contain items that are not needed to perform these services. The commenter suggested the following deletions: G0005 and CPT code 93270 (for the hookup of the equipment)—delete the ECG electrodes, laser paper, king of hearts-20, computer, life receiving center; G0006 and CPT code 93721 (for the monitoring and transmission of data)—delete the razor, gloves, alcohol swab, and tape and exam table; G0007 (interpretation and report)—delete all the supplies (G0007 currently has no equipment and CPT code 93272 currently has no equipment or supplies assigned).

Response: We agree that the changes to the practice expense inputs suggested above divide the inputs more appropriately between the two TC codes and the PC code for this cardiac monitoring service. However, as discussed in section IV, we are deleting the referenced G-codes for CY 2003 and these services will be reported using the CPT codes. On an interim basis, until these codes are refined, we will make the recommended revisions to the CPEP data for the CPT codes for these services. It should be noted, however, that the TC codes are currently in the non-physician work pool and that the CPEP data is not currently used to calculate their practice expense RVUs. In addition, we do not assign direct cost inputs to PC codes. Therefore, these changes will not at this time have any effect on the payment for these codes.

Comment: A specialty society representing radiology commented that the review cycle for pricing "high tech" equipment and supplies may need to be reviewed more frequently than every 5 years and suggested a 3-year cycle.

Response: We plan to propose current pricing for all the supplies and equipment in our CPEP database in next year's proposed rule. We have made no final decision on how often this pricing update should be done and will consult with the medical community on how best to ensure that we have appropriate pricing for all of our direct cost inputs.

(iv) *Proposed Changes from June 28, 2002 Proposed Rule*

(A) *Ophthalmology Services—Rank Order Anomalies*

Based on a request from the American Academy of Ophthalmology we proposed revisions to the CPEP data for five ophthalmology services: For CPT code 67820, *Revise eyelashes*, we proposed to remove ophthene from the supply list. For CPT code 67825, *Revise eyelashes*, we proposed to remove the bipolar handpiece from the supply list. For CPT code 65220, *Removal foreign body from eye*, we proposed using the supply list and clinical staff time assigned to CPT code 65222. The exam lane is the only equipment assigned. For CPT codes 92081 and 92083, *Visual field examination(s)*, we proposed to assign the same supplies and equipment as CPT code 92082 and to assign 35 minutes of clinical staff time to 92081 and 70 minutes to 92083.

Comment and Response: Commenters were supportive of the proposed revision to the CPEP inputs for the ophthalmology codes and we are finalizing the revisions as proposed.

(B) *Practice Expense Inputs for Thermotherapy Procedures*

There are three CPT codes for transurethral destruction of prostate tissue: CPT 53850, *by microwave therapy*, CPT 53852, *by radiofrequency thermotherapy*, and CPT 53853, *by water-induced thermotherapy (WIT)*. Based on concerns expressed by a manufacturer of WIT equipment that practice expense inputs were underestimated for CPT code 53853 relative to the other two codes, we made a comparison and agreed that the WIT procedure had not been assigned many of the basic supply and equipment inputs that were included in the CPEP inputs for the other two procedures. Therefore, we proposed to add, on an interim basis, the following inputs: Power table, ultrasound unit, mayo stand, endoscopy stretcher, light source,

chux, sani-wipe, patient education book, sterile towel, sterile gloves, specimen cup, alcohol swab, gauze, tape, lidocaine, betadine, 10 cc syringe, 30 cc syringe, sterile water, leg bag.

We also proposed to change on an interim basis the staff type for CPT code 53853 from the RN/LPN/MTA blend to RN in order to make the staff type consistent among these three similar procedures. In addition, we corrected, for all three procedures, the minutes assigned to each piece of equipment to reflect the intra- and post-clinical staff times only, rather than the total clinical staff times.

We have also requested that these three procedures be reexamined by the PEAC at the same time in order to ensure that there is a consistent approach to the assignment of direct cost inputs.

Based on questions we received regarding the large disparity in prices used for the three different thermotherapy machines and indications that the prices have decreased dramatically since these were initially priced in 1999, we proposed to set the price for thermotherapy equipment at \$60,000 for CPT code 53850 and \$30,000 for CPT code 53852. We also requested any additional available price documentation that would assist us in ensuring assigned prices accurately reflect actual costs.

Comment: Commenters were generally supportive of the proposed revisions and in agreement that the PEAC should review the CPEP inputs for these procedures. A specialty society representing urology agreed that the best way to handle the CPEP inputs for these services is to have the PEAC review the direct cost inputs for all the heat therapy procedures concurrently and the comment from the RUC stated that it plans to review these codes in time for inclusion in the physician fee schedule for 2004. However, a few commenters also suggested that the review be extended to other codes for treatment for benign prostatic hypertrophy, such as the code for transurethral resection of the prostate, CPT code 52612, and for laser coagulation of the prostate, CPT code 52647.

Response: We agree that it would be advantageous to have the PEAC review the CPEP inputs for all codes pertaining to the treatment of benign prostatic hypertrophy at the same time. This would help ensure that the same standards are applied to developing the direct cost inputs for these codes so that the resulting practice expense RVUs appropriately reflect the relative costs of each service. We will request that the

PEAC include for review all the codes suggested by the commenters.

Comment: One commenter, representing a manufacturer, also indicated that, as part of any review, it is imperative that cost data for all medical devices that fall within the CPT code should be evaluated. The commenter suggested that we work with the specialty groups to obtain pricing information rather than using invoices for pricing. The comment from the specialty society argued that we should maintain all the proposed input changes unless we receive compelling data from urologists or manufacturers that varies from the proposed inputs. Another commenter stated that, while there has been a reduction in the price of the thermotherapy control unit over the past few years, the proposed price of \$60,000 for thermotherapy equipment for CPT code 53850 was not representative. The commenter included an invoice that indicated that the current price is closer to \$80,000, after the application of discounts.

Response: We will finalize the revisions to the CPEP inputs as proposed with the exception of the price for the thermotherapy equipment that we will increase to \$80,000 on an interim basis. As part of the practice expense refinement process we have awarded a contract to update the pricing for both the supplies and equipment represented in the CPEP inputs and we anticipate that the proposed pricing revisions to the inputs will be included in next year's proposed rule. Pricing of the thermotherapy equipment will be included in these proposed changes and we will be seeking input from the specialty society to help us in this endeavor.

(C) Revision to Inputs for Iontophoresis

It had been brought to our attention that the electrodes assigned to the supply list for CPT code 97033, *Iontophoresis*, were not the type required for this procedure. We proposed to substitute two electrodes with a medication vesicle as the appropriate supply for iontophoresis.

(D) Correction to Price for Sterile Water

We proposed to change the price for 1000 ml of sterile water from \$40.00 to \$3.00.

Comments and Responses: No comments were received on our proposals to substitute two electrodes with a medication vesicle as the appropriate supply for iontophoresis or to correct the price of sterile water. Therefore, we are finalizing these as proposed.

b. Non-Physician Work Pool For Practice Expense

Comment: We received a comment objecting to use of the phrase "zero work pool." The comment acknowledges that our preamble refers to "zero physician work pool" but stated that the vernacular used by the agency, Congressional staff and other stakeholders is "zero work pool." While acknowledging that we do not intend to connote a zero value for oncology nurses' contributions, oncology nurses, social workers, radiology technicians and others take offense to the use of "zero work pool" because it suggests that the work done by oncology nurses and other clinical staff is without value. The comment suggested four appropriate alternative titles: Non-physician clinical staff time, Non-physician work components, Non-physician work pool or Non-physician health professional pool.

Response: We did not intend to devalue the contribution of clinical staff involved in providing physician fee schedule services. In fact, we created the special methodology to value services that are provided by clinical staff without a physician because of our concern that these services could be valued inappropriately low under the top down methodology. Nevertheless, it is clear that there are objections to the nomenclature we have used. We appreciate the suggestions for alternative nomenclature and will refer to the special methodology as the "Non-physician work pool."

(i) Discussion of Alternatives to the Non-Physician Work Pool

In our June 2002 proposed rule (67 FR 43850) we summarized alternatives to the non-physician work pool that have been included in reports prepared by our contractor, the Lewin Group. Included in the alternatives were: elimination of the non-physician work pool; development of specialty specific non-physician work pools; making the TC equal to the global less the PC RVUs; and, development of proxy physician work RVUs for physician fee schedule services provided by clinical staff without physicians. While we included a discussion of each alternative and their feasibility, we did not propose eliminating or replacing the non-physician work pool. We indicated that specialties whose services are affected by the non-physician work pool may conduct supplemental practice expense surveys if they believe there are shortcomings in the practice expense per hour information that we use as part of the basic methodology. We referenced

the interim final rule also published June 28, 2002 in the **Federal Register**. The interim final rule modified the criteria for acceptance of supplemental data. (See section II.A.3.(a) of this rule for a summary of the interim final rule, the public comments, and our responses.) We also noted that while the non-physician work pool is of benefit to many of the services that were originally included, we have allowed specialties to request that their services be removed.

As part of our analysis of alternatives to the non-physician work pool, we proposed a change in the computation of practice expense RVUs for some PC and TC services. Since it is far more common to receive a global bill than a TC only bill, we believe that using the global to value the TC service will result in a payment that is more typical of the relative actual practice expense associated with the service. Therefore, we proposed to make the TC value equal the difference between the global and the PC for procedure codes that are not included in the non-physician work pool. That is, we used the practice expense value produced by the methodology for the global and subtracted the PC to derive the TC practice expense RVU. As a result of concerns that we had about the impact of this change on services that are affected by the non-physician work pool calculations, we proposed continuing to make the global value equal to the sum of the professional and the TC values for non-physician work pool services.

Comment: One commenter, representing oncologists, argued that the "normal top-down methodology discriminates against [non-physician work pool] services * * * by assuming, without any basis, that indirect costs are lower than comparable services that do involve physician work." The commenter stated that both the GAO and Lewin reports provide support for the conclusion that the indirect cost allocation is biased against non-physician work services. According to the commenter, our assertion that "the indirect cost allocation must be correct because not all of the services without a physician work component are disadvantaged by its use is not a sound basis for maintaining the current methodology." The commenter argues that estimates of practice expense per hour and physician time may be overstated for some non-physician work services resulting in an advantage outside of the non-physician work pool. Furthermore, the comment argues that an increase in payment resulting from services being "withdrawn from the [non-physician work pool] does not demonstrate that the normal top-down

methodology results in an appropriate payment amount for services that do not have physician work components." The commenter also objected to our rejection of the Lewin Group's idea to develop specialty-specific non-physician work pools on the basis that a single methodology must apply to all services. According to the commenter, our refusal would only be appropriate if the methodology was not biased against non-physician work pool services. Another comment suggested that we allocated indirect costs by deeming direct costs as 33.2 percent of total costs. Indirect costs would then be added to direct costs to determine a total practice expense RVU.

Response: We do not believe the practice expense methodology is biased against non-physician work services. The methodology allocates indirect costs based on physician work and direct costs. While the comment suggests the use of physician work in the indirect cost allocation is biased against services that do not have physician work, it ignores that direct costs are also used. Most services that do not have physician work have significant direct expenses. Thus, any bias against non-physician work services in the indirect cost allocation is offset by the use of direct costs. Similarly, the use of physician work in the indirect cost allocation will offset any bias against services predominantly performed in facilities where the physician will have few, if any, direct costs associated with the services. For example, surgical services furnished in a hospital have few direct expenses, thus the allocation of indirect expenses according to both work and direct expenses helps offset any bias against surgical services.

We also disagree with the comment that suggests "deeming" direct costs to be 33.2 percent of total costs for purposes of developing practice expense RVUs. The proportion of costs attributable to direct and indirect costs will be different for each service. Such a proposal would be inherently unfair to services that have few direct costs (and impossible to use for services that have no direct costs) and would create a significant bias in favor of services that have high direct expenses.

We further examined the assertion in the comment and in the Lewin Group and GAO reports that the indirect cost allocation is a possible explanation for the adverse payment impact that would occur under the top-down methodology for some non-physician work pool services. It is important to distinguish between the different types of services that are affected by the non-physician

work pool calculations. Professional/TC services are the largest category of services included in the non-physician work pool. While many professional/TC services were not adversely affected by the adoption of the top-down methodology, the ones remaining in the pool are the services that would be most adversely affected by its elimination. Some "incident to" services are also included in the non-physician work pool. Elimination of the non-physician work pool may cause payments for these services to go up or down depending on the specialty that provides them.

Based on 2000 utilization data, the specialties with the largest amount of Medicare allowed charges affected by the non-physician work pool calculations are: radiology (\$2.8 billion), cardiology (\$2.1 billion), internal medicine (\$568 million), radiation oncology (\$465 million), multi-specialty clinics (\$313 million), independent diagnostic testing facilities (\$309 million) and oncology (\$226 million). Radiology receives 87 percent of its Medicare revenues from services that are affected by the non-physician work pool calculations. The figures are 47 percent for cardiology, 9 percent for internal medicine, 65 percent for radiation oncology, 17 percent for multi-specialty clinics, 86 percent for independent diagnostic testing facilities and 26 percent for oncology. There are other smaller specialties that also receive a significant proportion of their revenues from services in the non-physician work pool (portable x-ray suppliers, 100 percent, interventional radiology, 63 percent, allergy/immunology 35 percent). The specialties that receive the highest proportion of their revenues from professional/TC services remaining in the non-physician work pool would be most adversely affected by its elimination (independent diagnostic testing facilities, portable x-ray suppliers, radiology, radiation oncology and interventional radiology). Cardiology also receives substantial Medicare revenues from professional/TC services remaining in the non-physician work pool but would be less adversely affected by its elimination. Allergy/immunology receives substantial revenues from "incident to" services in the non-physician work pool and would experience a more modest decline in payment under the top-down methodology. Payments to oncology for "incident to" services would increase if the non-physician work pool were eliminated.

Radiology, radiation oncology and certain other diagnostic services with professional and technical components

are likely to be the services most adversely affected by elimination of the non-physician work pool. We do not believe the allocation of either direct or indirect costs explains the effect of the top-down methodology on these services. We examined this issue further by modifying the indirect cost allocation using an idea suggested by the Lewin Group that would retain work and direct expenses to allocate indirect costs but create proxy physician work values for services that do not have physician work (the Lewin Group, pages 22–23). As indicated earlier, we proposed to modify the practice expense methodology to calculate the TC practice expense RVU as the difference between the global and the PC RVU for services unaffected by the non-physician work pool. To analyze the Lewin idea, we followed this same approach for all services. However, we further modified the methodology to use proxy work RVUs for the TC (or non-physician work portion) of the global service for the allocation of indirect costs. (We did this for TC services as well, but it makes no difference whether a proxy physician work RVU is used for the indirect cost allocation since the RVU produced by the practice expense methodology for the TC is not used). By developing a proxy work RVU for the global, in effect, we imputed physician work RVUs for the technical portion of the global service and added it to the existing work RVUs for the physician interpretation. If such an approach were adopted, the indirect cost allocation would favor the global service at the expense of professional component. That is, the practice expense RVUs would increase for the global and decrease for the PC but the overall impact for the specialty would be about the same. Modifying the indirect cost allocation in this way would not offset large decreases in payment for radiology, radiation oncology and other specialties most adversely affected by elimination of the non-physician work pool. In fact, such a methodological change would not even raise payments to these specialties.

As we indicated in the June 2002 proposed rule, we believe a relatively low practice expense per hour, and not the indirect cost allocation, explains the adverse impact on diagnostic services that would occur from eliminating the non-physician work pool. We encourage radiology, radiology oncology and other diagnostic service providers affected by the non-physician work pool to undertake a survey of the practice expenses. Since practice expense

methodology uses a weighted average of the practice expenses of the specialties that bill Medicare, we believe there are significant advantages to the survey being undertaken with collaboration among the different providers of diagnostic services. As indicated earlier, we advise any party interested in conducting a supplemental survey to consult the Lewin Group and us before proceeding.

Comment: Most comments we received supported making the TC practice expense RVUs equal to the difference between the global and PC practice expense RVUs. We received a number of comments from pathologists and organizations representing independent laboratories, pathologists, dermatologists, and others expressing concern about the effect of the proposal on payment for pathology services. Some of the commenters indicated that we did not provide an explanation of the necessity for the change or indicate why a simple arithmetic change should result in such a large difference in the proposed fee for TC services. Several of these commenters stated that practice expenses for physician pathology services are increasing, not decreasing. According to some of these commenters, it is inequitable to apply the methodology to certain specialties or groups of services that would experience significant reductions while sparing other specialties or services that would experience reductions under the same change. There were also comments indicating that the reduction in payment for pathology services was related to the mix of specialties that bill for global services; specifically, there is concern that independent laboratories bill for a higher proportion of global than TC services. The commenters noted that we do not have a practice expense per hour for independent laboratories and use a crosswalk practice expense per hour from “all physicians.” While this comment acknowledges our need to use a crosswalk when we do not have a practice expense per hour, the comment indicated that there is no reason to conclude that independent laboratories that provide pathology services have practice expenses per hour similar to the all physician average. The comments expressing concern about the impact of the proposal on pathology services requested a one-year moratorium on its implementation to allow for a survey of independent laboratory practice expenses under the supplemental survey process. There were a number of comments indicating that organizations representing

pathologists would undertake a survey of practice expenses for independent laboratories that could be used to develop 2004 physician fee schedule rates.

Response: We agree with the comments that suggest a one-year moratorium on implementation of the proposed change for pathology services paid under the physician fee schedule. Based on a consultation with the College of American Pathologists, we will continue to determine the global practice expense RVUs as the sum of the professional plus TC for all of the global codes in the CPT 80000 series that are paid using the physician fee schedule, as well as the following HCPCS and CPT codes:

TABLE 2

CPT/HCPCS	Description
G0141 ...	Screening c/v, autosys, interp
P3001	Screening c/v, interp
10021	FNA w/o image
10022	FNA w/image
36430	Blood transfusion service
36440	Blood transfusion service
36450	Blood transfusion service
36455	Exchange transfusion service
36460	Transfusion service, fetal
36520	Plasma and/or cell exchange
38220	Bone marrow aspiration
38221	Bone marrow biopsy
38230	Bone marrow collection
38231	Stem cell collection

CPT codes and descriptions only are copyright 2002 American Medical Association.

As we indicate in the background part of this preamble, the practice expense methodology essentially takes a weighted average of different specialty practice expenses to determine a practice expense RVU. The methodology will independently produce a value for the global, professional and technical components. For instance, CPT code 88305 (Tissue exam by pathologist) is a commonly provided pathology service. The methodology produces a value of 1.60 for the global, 0.34 for the PC and 1.39 for the technical component. The sum of the professional and TC RVUs (0.34 + 1.39 = 1.73) is not equal to the global RVU (1.60). The values are not equal because the mix of specialties that provide the global and the TC are different and each specialty has a different practice expense per hour. The specialties that bill CPT code 88305 to Medicare for the global service most frequently have the following practice expense per hour:

TABLE 3

Specialty	Practice expense per hour	Percent of total volume
Independent Lab	\$69.00	56
Pathology	66.30	29
Dermatology	119.40	13

The specialties that bill Medicare most frequently for the TC are:

TABLE 4

Specialty	Practice expense per hour	Percent of total volume
Independent Lab	\$69.00	47
Dermatology	119.40	33
Pathology	66.30	16

As shown in the tables above, dermatology has a very high practice expense per hour relative to independent laboratories and pathology. However, dermatologists bill Medicare for a smaller portion of the global services. As a result, dermatology contributes less weight to the global value than the TC value. Our practice has been to make the global RVUs equal the sum of the PC and TC values. If the methodology results in PC and TC values that do not sum to the global value, we must change either the global or TC value. To date, we have used the PC (0.34) and the TC value (1.39) to determine the global value (1.74). However, in the proposed rule, we used the global value (1.60) minus the PC (0.34) to obtain the TC (1.26). Using the TC to value the global component for this code (88305) produces a higher RVU for both the technical and the global components than using the global component to value the TC.

As we have previously indicated, it is far more common for Medicare to receive a global than technical-component-only bill. For this reason, we believe it is valid to rely on the global to produce a value for the technical rather than use the technical to value the global. Nevertheless, since independent laboratories predominantly bill the global for pathology services and we are using a crosswalk for the practice expense per hour, we believe it makes sense to allow for a one-year moratorium on implementation of this provision for pathology services to allow for use of a supplemental survey that provides us with specific data on practice expenses for independent laboratories.

Final Decision: We are not adopting the proposed change for pathology

services paid using the physician fee schedule at this time. For all professional/TC services not included in the non-physician work pool, excluding pathology services, we will make the TC value equal the difference between the global and the professional component. We will continue with the current practice for pathology services and non-physician work pool services and sum the professional and TC values to determine the global.

(ii) Other Proposals for Changes to the Non-Physician Work Pool

(A) Change to Staff Time Used To Create the Pool

In the November 2, 1998 final rule (63 FR 58841), we indicated that average clinical staff time was used in the creation of the non-physician work pool. Since the cost pools are created using physician time and, by definition, services provided by clinical staff have no physician time, we need staff time to create the non-physician cost pool. If our database indicates that multiple staff types are typically involved in the service, we have used an average of the different clinical staff times. We proposed to create the non-physician cost pool using the highest staff time in place of average staff time.

Comment: We received many comments that supported using the highest staff time to create the non-physician work pool. Some comments suggested that we should consider using “total” staff time especially if we will use the clinical staff times being provided by the Practice Expense Advisory Committee (PEAC). The comment indicates that the PEAC has been particularly careful to avoid duplications of time. If the PEAC has limited or eliminates concurrent staff time, the comment suggests that “total”

rather “maximum” staff time should be used to determine the non-physician work pool. A number of comments expressed concern about PEAC refinements of clinical staff times associated with codes included in the non-physician work pool. These comments requested that we not incorporate any PEAC revised clinical staff times for non-physician work services until there has been an opportunity for public notice and comment. There were two comments objecting to this proposal. One comment indicated that the maximum staff time is not the “typical” time associated with provision of the service and urged us not to implement the proposal. We received another comment that noted that physician times used to establish practice expense cost pools for physician work services use average or median times from RUC or Harvard surveys. The comment indicates that the proposal to use maximum staff time represents a step away from the stated goal of developing a consistent method for all services. According to this commenter, the proposal will penalize specialties that do not perform a large volume of services in the non-physician work pool.

Response: We disagree with the comment that suggests we are not using a time that is typical of the service and the one that implies our staff time proposal is inconsistent with how we determine physician time. For a physician’s service, we develop time based on surveys. While the comment is correct that we generally use average or median time estimates from surveys to determine the typical time, the time reflects the service of a single physician.

For non-physician work pool services, we are also using estimated average staff times to represent the typical service. However, multiple clinical staff are frequently involved in performing non-physician work pool services. The staff may be working concurrently, consecutively or overlapping time. Given the special circumstances associated with non-physician work pool services that do not apply to physicians' services, it was necessary for us to select among multiple time estimates to develop the pool. We are currently using an average of the estimated staff times but proposed to use the maximum. Once we address issues related to the non-physician work pool, this will no longer be an issue since we will use a single methodology for all physician fee schedule services and staff time will not be used to create cost pools.

In response to the comment that refined clinical staff times not be used at this time for non-physician work pool services, we agree that there are special circumstances that apply to these services. Because the clinical staff times are used to create the pool and can result in RVU changes across all services, even those where no refinements have been made, we are not using the revised clinical staff time to create the non-physician work pool at this time. However, as indicated above, this will no longer be an issue once we address other issues related to the non-physician work pool.

(B). Removal of Non-Invasive Vascular Diagnostic Study Codes From the Non-Physician Work Pool

We proposed to remove the non-invasive vascular diagnostic study codes (CPT codes 93875–93990) from the non-physician work pool based on a request from the American Association for Vascular Surgery (AAVS) and the Society for Vascular Surgery (SVS).

Comment: We received support from vascular surgeons and others for removing the non-invasive vascular diagnostic studies from the non-physician work pool. These comments requested that AAVS/SVS should be able to modify the request if CMS does not finalize its proposal to calculate the TC practice expense RVU as the difference between the global and professional components. We also received a number of comments requesting that we remove other codes from the non-physician work pool. The Society of Vascular Technology and Society of Diagnostic Medical Sonography requested that we remove 26 ultrasound codes in the CPT code range 76506 through 76977. The

American Society of Neuroimaging also requested that some of these codes be removed. The American Urological Association (AUA) also requested that we remove CPT codes 76857, 76872, 76942 and 96400 from the non-physician work pool. While there were no objections to removing the non-invasive vascular diagnostic study codes, we received many comments that suggested limiting the financial impact that removing codes from the non-physician work pool have on the remaining codes. In particular, many of these commenters expressed concern about the impact of removing chemotherapy administration codes from the non-physician work pool. Some comments provided suggestions for modifications to the non-physician work pool (for example, using a different practice expense per hour) that could be used if adverse impacts result from codes being removed. One commenter suggested that we maintain the existing RVUs and provide a downward adjustment to the CF to ensure no increase in aggregate payment results from removing chemotherapy administration services from the non-physician work pool.

Response: At this time, we have not received any requests to remove chemotherapy administration from the non-physician work pool. Nevertheless, if there are sound suggestions that could be adopted consistent with changes in the composition of the non-physician work pool that will improve the practice expense methodology, we may consider adopting them in the future. Of course, as stated elsewhere, our goal is to eliminate the non-physician work pool and apply a single methodology to all physician fee schedule services so further adjustments will be unnecessary. We expect this to be a top priority in CY 2003 for determining CY 2004 physician fee schedule rates.

We have reviewed the comments to remove specific services from the non-physician work pool. While our general policy has been that "families" of procedure codes should be removed from the non-physician work pool (see the July 22, 1999 proposed rule (64 FR 39620)), we will allow individual codes to be removed if the requesting specialty predominantly performs the requested code and other specialties predominantly perform the other codes in the family. We have reviewed 2001 utilization for the codes requested by the AUA. Since urologists predominantly perform the requested codes and other codes in the family are predominantly performed by other specialties, we are removing the following codes from the non-physician

work pool: CPT codes 76857, 76872, 76942 and 96400. We are not removing other codes requested in the comments because they are predominantly performed by radiology, neurology or obstetrics-gynecology and the specialty societies representing these physicians have not requested that the codes be removed from the non-physician work pool.

Comment: The American College of Rheumatology (ACR) acknowledged that the current average wholesale price (AWP) methodology provides for a "healthy margin overall" in the provision of these services [infusion agents and infusion therapy] through "cross-subsidization." However, they indicated that payments for infusion therapy services are "woefully insufficient." The comments from ACR and many rheumatologists expressed concern about reductions in payment for infusion agents in combination with maintaining the current payment amounts for infusion therapy (CPT codes 90780 and 90781). The comments indicated that a reduction in payment for infusion agents without an increase in the payment for infusion therapy services will likely result in Medicare beneficiaries being unable to receive infusion services in physicians' offices. One commenter from a society representing gastroenterologists indicated that we should consider increasing the payment for non-chemotherapy infusion services. Other comments suggested that we should use the rulemaking process to establish HCPCS G codes to increase payment for non-chemotherapy drug administration to a more appropriate level.

Response: We currently determine the practice expense RVUs for CPT codes 90780 and 90781 using the non-physician work pool methodology. One commenter suggested establishing a G code for non-chemotherapy infusion services. While this option would allow infusion therapy to be valued outside of the non-physician work pool, we want to avoid establishment of G codes for services that are already described by existing CPT codes. Another option for addressing these comments would be to remove infusion therapy from the non-physician work pool and allow for resource-based pricing under the top-down methodology. However, oncologists predominantly perform these services and have not requested removing the codes from the non-physician work pool. We are reluctant to remove infusion therapy services from the non-physician work pool without a request from the specialty that predominates the data. As we previously noted, oncologists provided

us with a supplemental practice expense survey. At this time, we are not incorporating the survey into the practice expense methodology because of concerns raised by our contractor, the Lewin Group, about the validity of some of the data. However, we hope to work with the Lewin Group and ASCO to either get an explanation of the survey results or use alternative data to validate the results. As we work to resolve issues related to the ASCO survey, we will consider removing the infusion therapy codes from the non-physician work pool.

In the interim, we note that Medicare pays for drugs based on 95 percent of AWP. This system has been widely criticized for paying physicians for drugs at far higher rates than prices paid to obtain them. Oncologists receive more than 70 percent of their Medicare revenues from drugs. While we would prefer a statutory change to address Medicare's drug pricing methodology, we are contemplating administrative actions that may be taken under current law to address this issue. As we consider options for changing Medicare's drug payment methodology, we will continue examining the ASCO survey to determine whether the data can be used to calculate the practice expense per hour for oncology.

(C) Removal of Immunization CPT Codes 90471 and 90472 From the Non-Physician Work Pool

We proposed to remove immunization administration services from the non-physician work pool. We indicated this change would nearly double payment for CPT code 90471 and slightly reduce payment for CPT code 90472. Procedure CPT code 90471 is used for immunization administration of one vaccine and CPT code 90472 is used for the administration of each additional vaccine. Since CPT code 90472 must be billed in conjunction with CPT code 90471, the total payment for these procedures would increase when billed together.

We also explained that we have not assigned immunization administration physician work RVUs because this service does not typically involve a physician. The nurse that administers the vaccine typically provides the necessary counseling to the patient and this time is accounted for in the practice expense RVU.

In addition, we noted that not all services represented by CPT codes 90471 and 90472 are covered by Medicare. For example, medically necessary administrations of tetanus toxoid (such as following a severe injury) would be covered whereas

preventive administration of this vaccine would not be covered. We also indicated we would consider whether coding changes might be appropriate to reflect the differences in counseling of the patient and/or family for childhood immunizations.

Comment: Commenters supported our proposal to remove CPT codes 90471 and 90472 from the non-physician work pool. However, commenters indicated elderly patients are at higher risk to acquire pathogens and viruses and are in greater need of vaccinations. Medicare must recognize that as part of their practice of medicine, physicians take the time and responsibility to explain to their patients the benefits of vaccination and the potential side effects. Physicians question the patient about previous reactions to the vaccine and provide information material. These comments indicated that we should assign work RVUs of 0.17 for the administration of vaccines as recommended by the RUC.

Response: The RUC has recommended that we both establish a work RVU for CPT code 90471 and include 13 minutes of clinical staff time to value the practice expense RVU. Further, our understanding from the RUC is that these immunization services are also provided in conjunction with a separately billable visit. We believe the clinical staff time for these services is intended to account for patient counseling and some of the activities described in the comment. Other activities attributed to the physicians are likely being provided as part of a separately billable office visit. For these reasons, we continue to believe that these codes should not be assigned physician work RVUs.

Comment: Several commenters expressed concern that we did not propose any change in the payment rate for the administration of influenza (G0008), pneumonia (G0009), and hepatitis B (G0010) vaccines. The commenters are concerned that we continue to link payment for the administration of Medicare covered vaccines to a therapeutic injection CPT code (90782) that pays at half of the proposed rate for CPT code 90471. Other commenters recommended that Medicare use the CPT codes 90471 and 90472 in place of the Medicare-only alphanumeric codes (G0008, G0009, G0010). These comments indicated that if we are to retain the G codes, we should publish RVUs for them that match CPT code 90471.

Response: We considered the comment to eliminate use of the G codes and allow use of the CPT codes for the administration of Medicare covered

vaccines. However, we have decided that we will maintain these G codes at this time. It is important that we be able to closely monitor patient access to these important preventive services. However, since CPT has established similar codes for immunization administration that can be covered by Medicare, we will consider this issue further in 2003.

With respect to payment, we agree with the commenters. Rather than link payment for procedure codes G0008, G0009, and G0010 to a service paid under the physician fee schedule, we will develop practice expense RVUs for these codes. Using the top-down methodology to develop practice expense RVUs will nearly double payment for these codes and make Medicare's payment for vaccine administration using the G codes more consistent with the rates paid for the CPT codes. Since the statute does not include the administration of pneumonia, influenza, and hepatitis B vaccines within the definition of physicians' services in section 1848(j) of the Act, the increased payment for these services will not result in reductions to the practice expense RVUs associated with physician fee schedule services. That is, there is no budget-neutrality adjustment to be made for revisions in payments for the administration of pneumonia, influenza, and hepatitis B vaccines.

Comment: One commenter indicated that Medicare does not pay for the administration of influenza and pneumonia vaccines provided on the same day as another physician's service.

Response: The commenter is incorrect. Medicare will pay separately for the administration of these vaccines and other physicians' services on the same day.

(D) Utilization Data

Medicare utilization is an important data source used in determining the practice expense RVUs. Our current policy has been to use the latest utilization data to develop each successive year's fully implemented practice expense RVUs during each year of the transition. While substituting the latest year's utilization data into the practice expense methodology generally made little difference on total Medicare payments per specialty, there has been a larger impact on services affected by the non-physician work pool. Based on suggestions made by specialty organizations, we proposed to use the CYs 1997 through 2000 utilization data to develop the CY 2003 practice expense RVUs and not to update further the utilization data in this year's final rule

to incorporate the CY 2001 utilization data. Further, we proposed to continue using the CYs 1997 through 2000 utilization data in the practice expense methodology until we undertake the 5-year review of practice expense RVUs.

Comment: We received comments both supporting and opposing use of multi-year utilization data in the practice expense methodology. The comments that “applauded CMS’s efforts to ensure the stability” of the practice expense RVUs largely came from organizations affected by the non-physician work pool methodology. We also received support from specialties that are largely unaffected by the proposal because of its potential to provide more year-to-year stability in the practice expense RVUs. Other commenters indicated that use of new utilization data with a different “mix” of services produces unpredictable changes in RVUs even though resource costs have not changed. There were comments that indicated use of multi-year utilization data will restore the unanticipated and extraordinary reductions experienced by diagnostic imaging centers in CY 2002. These commenters urged that we adopt our proposal in the final rule. One comment stated that “utilization data adjustments should not change annually until the [non-physician work pool] is eliminated and/or CMS undertakes the 5-year review of practice expense RVUs.”

One commenter stated that it is unclear whether the multi-year utilization will be used to develop practice expense RVUs for all services or only those in the non-physician work pool. Another commenter stated it is difficult to assess the impact of the proposal and urged the agency “not to make such a change, at least until it has conducted extensive impact comparisons” that can be evaluated by physicians and other stakeholders. Other commenters suggested that we should not update the practice expense methodology with new utilization data without giving an opportunity for public notice and comment. A number of commenters argued that application of a 10-percent payment reduction in CY 1998 and the per beneficiary per facility payment cap of \$1500 cap in CY 1999 (in settings other than outpatient hospital departments) make utilization data unreliable for therapy services during the CYs 1997 through 2000 period. Commenters also noted that outpatient physical and occupational therapy services provided in facility settings were paid under cost-based reimbursement before CY 1999. The commenters questioned the accuracy of the utilization data for Part B therapy

services from CYs 1997 through 2000 and suggested that the utilization data during this period would be biased by the implementation of policy changes. One commenter recommended that we use the most current available data as the base for examining therapy utilization and should commit to an annual review of the data until it can be established that a longer time horizon accurately reflects utilization. Other comments requested clarification of how we use data from this period for physical and occupational therapy.

Response: With respect to therapy services, we do not use claims of institutional providers (rehabilitation agencies and comprehensive outpatient rehabilitation facilities) in developing payment rates for therapy services paid using the physician fee schedule. We only use the claims for therapy services from physical and occupational therapists in private practice. The proposal was intended to apply to all physician fee schedule services, not just those in the non-physician work pool. We are finalizing our proposal to use the CYs 1997 through 2000 utilization data to develop the practice expense RVUs for all services. However, we believe the comments raise important issues about policy changes that were occurring from CYs 1997 through 2000 that could lead to changes in utilization patterns during this time. We may analyze this issue further. In the interim, we welcome public comment about using the latest utilization data in the practice expense methodology.

(E) Site of Service

As part of our resource-based practice expense methodology, we make a distinction between the practice expense RVUs for the non-facility and the facility setting. This distinction is needed because of the higher resource costs to the physician in the non-facility setting where the practitioner typically bears the cost of the resources associated with the service. In addition, the distinction ensures that we do not make a duplicate payment for any of the practice expenses incurred in performing a service for a Medicare beneficiary. Currently, we have designated only hospitals, skilled nursing facilities (SNFs), and community mental health centers (CMHCs) as facilities for purposes of calculating practice expense. An ambulatory surgical center (ASC) is designated as a facility if it is the place of service for a procedure on the ASC list. All other places of service are currently considered non-facility.

We proposed site-of-service designations for several new places of

service as well as revisions to the site-of-service designation for several existing places of service. We proposed to assign a facility site-of-service when a facility or other payment will be made, in addition to the physician fee schedule payment to the practitioner, to reflect the practice expenses incurred in providing a service to a Medicare patient. We proposed to designate all other places of service as non-facilities.

The following lists the place of service numerical code, the place of service and the proposed site of service designations:

- 04 Homeless Shelter—Non-facility
- 15 Mobile Unit—Non-facility, however, if a mobile unit provides a service to a facility patient, the appropriate place-of-service code for the facility should be used.)
- 20 Urgent Care Facility—Non-facility
- 26 Military Treatment Facility—Facility
- 41 Ambulance-Land—Facility
- 42 Ambulance Air or Water—Facility
- 52 Psychiatric Facility Partial Hospitalization—Facility
- 56 Psychiatric Residential Treatment Facility—Facility (NOTE: the chart included in the June 28, 2002 proposed rule at 67 FR 43854 incorrectly listed this as “NF”—nonfacility)

We would also clarify two items in the chart published at 67 FR 43854:

- 61 Comprehensive Inpatient Rehabilitation Facility was listed as a non-facility. This is currently considered a facility setting and we did not propose changing this designation. The reference to non-facility was in error.

We also made reference to four place of service codes for Indian Health Service and Tribal 638 facilities and clinics. We were considering these place of service codes to implement section 432 of the BIPA that authorizes physician fee schedule payments to Indian Health Service and Tribal 638 facilities and clinics. At this time, we do not believe these place of service codes will be needed for implementation of these provisions and do not expect them to be in use. We are implementing section 432 of BIPA by using specialty codes, not place of service codes to identify HIS providers.

Comment: One organization expressed appreciation for our efforts to update the list and had no comments. Others commented requesting clarification of site-of-service designations for the provision of Part B therapy services in nursing facilities. One commenter expressed particular concern about the use of place of service

code 32 (Nursing facility) in conjunction with outpatient therapy services in nursing facilities. This commenter suggested we reiterate in the final rule the current policy that fee schedule payments for Part B therapy services delivered in a nursing home are classified as “non-facility.” They also suggested we redefine “site-of-service” for physicians services to non-Part A patients in nursing centers as “non-facility,” thereby applying the higher PERVUs to those services. We received one comment from a carrier medical director that indicated that physician practice costs for treating patients in skilled nursing facilities (POS 31) and nursing facilities (POS 32) are the same and that both should be designated as either facility or non-facility. This comment also suggested deleting the POS 32 designation (NH), or changing its meaning to a “SNF or NF stay not covered by Medicare.” A physician who practices in nursing facilities also argued that our current policy makes no sense because physician practice costs are the same regardless of whether Medicare makes a payment to the SNF for institutional services. This physician would like us to pay at the higher non-facility rate for physicians’ services in both entities, but acknowledged that using the lower facility rate would be more consistent with the practice expense methodology.

Response: We regret any ambiguity or concern that we may have created in our proposed rule. In general, for purposes of the physician fee schedule, we will consider a site to be a facility if the site also receives a Medicare payment for institutional services (that is, a payment under the inpatient prospective payment system (PPS), outpatient PPS, and SNF PPS). Thus, since there is a payment for institutional services to a hospital when a beneficiary receives care in an inpatient or outpatient setting, we consider the site to be a facility site and make a payment under the physician fee schedule using the facility rate. For entities other than those that receive a payment for institutional services, we consider the site a non-facility site and pay under the physician fee schedule using the higher non-facility rate. However, there are special provisions with respect to outpatient physical and occupational therapy services. These services are paid under the physician fee schedule even when provided in institutional sites like skilled nursing facilities. For this reason, for these services we calculate only a non-facility rate. Since there is no facility payment under Medicare, we

use a non-facility rate to determine payment.

Place of service code 32—Nursing facility—was designated as non-facility in our June 2002 proposed rule. Place of service code 31—Skilled nursing facility—is designated as facility. We have instructed physicians to use place of service code 31 for patients who are in an inpatient stay in a skilled nursing facility. Since Medicare is making a payment for institutional services that includes compensation for staff, supplies, and equipment, we are paying physicians using the lower facility rate when place of service code 31 is used. If the patient exhausts eligibility for SNF benefits and Medicare is no longer making payment to the SNF for institutional services, we have instructed physicians to use place of service code 32—Nursing facility, to allow Medicare to provide compensation to the physician for the costs of staff, supplies and equipment that would otherwise not be included in our payment. However, since it may be burdensome to the physician to determine when a patient is entitled to SNF Part A benefits, we always allow the physician to use place of service 31 and receive the lower facility payment for physicians’ services.

While we acknowledge the arguments of those who have written and contacted us both prior to and as part of the rulemaking process, we are reluctant to make any further changes in our policy at this time. We believe existing policy is equitable in that it does not overly burden physicians to have to determine whether a patient is in a Part A SNF inpatient stay. Physicians can always bill using place of service code 31 and be paid at the facility rate. Further, we allow use of place of service code 32 and our payment will be at the higher non-facility rate that includes compensation for staff, equipment, and supplies that would not otherwise be paid since there is no payment for the institutional services. In response to the request that we change the nomenclature describing place of service code 32, we will consider this further as updates are made to place of service coding. However, we note that Medicaid uses the place of service codes as well and the needs of this program will also need to be considered.

Comment: One commenter suggested the descriptor for place of service code 23, “emergency room-hospital,” should be changed to “emergency department.”

Response: We will consider this comment when further updates are made to place of service codes.

Comment: One commenter expressed concern about the proposed designation

change of site of service from non-facility to facility for both psychiatric facility partial hospitalization and psychiatric residential treatment facility. The commenter felt this would negatively impact physician reimbursement and could provide disincentive for psychiatrists to treat patients in these settings.

Response: By developing practice expense RVUs that differ by site, we intend to reflect the relativity of resource costs incurred by physicians between sites. Our policies are not intended to provide financial incentives for a physician to select one site over another. Physicians should make these decisions based on the clinical needs of the patient. We believe that both psychiatric residential treatment facilities and psychiatric partial hospitalization programs are institutional sites that provide staff, equipment and supplies used in providing medical services and physicians will not incur these resource costs when providing services in these settings.

(F). Other Practice Expense Issues

(1) Budget Neutrality

We received several comments suggesting that budget neutrality for changes in practice expense RVUs be applied to the physician fee schedule conversion factor. The comments indicated that payment for CPT codes with significant practice expense RVUs are reduced when there are aggregate increases in work RVUs but services that are predominantly composed of work RVUs are not significantly affected by aggregate increases in practice expense RVUs. According to the comments, such a modification would “help assure more year-to-year stability in the practice expense RVUs.” Since affected professional groups have not had an opportunity to consider and comment on this important issue, one comment suggests that we include this issue in the proposed notice for the CY 2004 physician fee schedule.

Response: We will consider this idea for the future.

(2) Computerized Tomographic Angiography

Comment: We received a number of comments about Computed Tomographic Angiography (CTA). The comments indicated that, before CY 2001, CTA services were billed as a CT scan of an anatomical region plus an add-on code for 3-D image reconstruction. New codes specifically for CTA that incorporated the image reconstruction were developed for use

in 2001. The comments indicated that the TC RVUs for CTA established in the November 1, 2000 final rule appear as though they were calculated by cross-walking the RVUs from the anatomically analogous existing CT procedure codes without accounting for the 3-D image reconstruction.

Response: Based on this comment, we have adjusted the current CTA codes to incorporate image reconstruction.

(3) TC for Cardiac Catheterization

Comment: We received several comments that noted the TC RVU for cardiac catheterization declined in the notice of proposed rulemaking even though the codes are included in the non-physician work pool. These comments noted that the practice expense RVUs for all other non-physician work pool services increased in the proposed rule. One comment expressed concern over our proposal to derive the TC RVU from the global RVU service. The comment indicated that we currently have no direct cost inputs for these services and it is unlikely that the PEAC will be able to provide them since cardiac catheterization is generally provided in hospital settings. According to the commenter, there are only 80–100 non-hospital facilities that provide cardiac catheterization services. It is unlikely that we will have physician survey information that reflects the costs of these providers since they normally bill for the TC service and not the global service. The comment stated the cardiologist normally bills independently for professional services.

Response: We have addressed the comment regarding the TC for the cardiac catheterization. The TC RVUs for these services are changing by the same percentage as all other non-physician work pool services. We understand that the PEAC may consider providing inputs for cardiac catheterization services. This will address one aspect of the commenter's concern. With respect to valid SMS data for cardiac catheterization services, we will consider this issue along with others as we address issues related to the non-physician work pool in CY 2003.

B. Anesthesia Issues

1. Five-Year Review of Anesthesia Work

Section 1848(b)(2)(B) of the Act indicates that, to the extent practicable, we will use the anesthesia relative value guide with appropriate adjustment of the anesthesia conversion factor (CF) in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule

amounts for other services. The statute also requires us to adjust the CF by geographic adjustment factors in the same manner as for other physician fee schedule services. Unlike other physician fee schedule services, anesthesia services are paid using a system of base and time units. The base and time units are summed and multiplied by a CF. The base unit is fixed depending on the type of anesthesia procedure performed, and the time units vary based on the length of the anesthesia time associated with the surgical procedure. Thus, our payment will increase as anesthesia time lengthens. The same anesthesia service provided in two different surgeries will be paid different amounts if the associated anesthesia time is different. This system differs from other physician fee schedule services for which RVUs for physician work, practice expense, and malpractice are summed and multiplied by a CF to determine payment. Payment for these non-anesthesia procedures will not vary based on the length of time it takes to perform the procedure in a specific instance.

In the June 2002 proposed rule (67 FR 43855) we explained that the law requires that we review RVUs no less often than every 5 years. There is a fundamental difference in how the 5-year review applies to anesthesia services versus medical and surgical services. In general, for medical and surgical services, the relevant physician specialty society and the AMA's RUC review the current and proposed work RVUs on a code-by-code basis. The RUC will make recommendations to us on work values for specific codes and, if we accept or modify them, the new physician work RVUs will be used to determine payment. However, each anesthesia service does not have a work RVU. Therefore, adjustments for anesthesia work (and practice expense) are made to the anesthesia CF and payment for all anesthesia services is affected.

The second 5-year review (with the exception of anesthesia services) was completed and revised work RVUs were implemented in 2002. For the second 5-year review, the American Society of Anesthesiologists (ASA) contended that the work of anesthesia services remained undervalued by almost 31 percent. They subsequently argued for a 26 percent increase in work RVUs based on additional discussions with the RUC. More recently, based on their further analysis and discussion with the RUC, the ASA asked for a 13.6 percent increase in work.

The ASA derived a work value for an anesthesia code by dividing the anesthesia service into five uniform components. The five components are preoperative evaluation, equipment and supply preparation, induction period, postinduction period, and postoperative care and visits. These components were assigned work RVUs based on a comparison to non-anesthesia services paid under the physician fee schedule. The work of these components is then summed. Using this method, the ASA proposed new work values for 19 high volume anesthesia codes. These work values can be compared to imputed work values derived from current anesthesia payments for these services.

Under the CPT coding system, anesthesia for various common surgical procedures is reported under a single anesthesia code. For example, CPT code 00790 is used to report anesthesia for over 250 intraperitoneal procedures in the upper abdomen.

The ASA studied one surgical procedure for each of the anesthesia codes. The 19 codes represent a range of surgical procedure types, including general surgery, vascular surgery, neurosurgery, urology, orthopedics, cardiac surgery, and ophthalmology. The 19 procedures reviewed account for about 35 percent of Medicare allowed charges for anesthesia services.

During the second 5-year review of work, several RUC workgroups reviewed the ASA comments and received supplemental information from them through presentations. Most of these workgroups expressed concerns about some of the work intensity values the ASA assigned to the individual anesthesia components, most notably, the induction and post induction time periods. For about 50 percent of the codes, the RUC was confident that the anesthesia work value of the surveyed service was similar to the anesthesia work values for all of the other surgical services assigned to the given anesthesia code. For the remaining codes, the RUC was not confident that the work values of the surveyed code could be applied to other anesthesia services that would be reported under that anesthesia code.

The workgroups also expressed concern about extrapolating the results from the 19 surveyed codes to all anesthesia services. At its April 2002 meeting, the final meeting addressing anesthesia work values for the second 5-year review, the RUC concluded it was unable to make a recommendation regarding modification to the physician work values for anesthesia services. Specifically, the RUC stated:

The RUC, having carefully considered the information presented, and having a

reasonable level of confidence in the data, which was presented and developed by the ASA, is unable to make a recommendation to CMS regarding modification to the physician work valuation of anesthesia services.

While the RUC did not make a recommendation to us regarding extrapolation, it forwarded its analysis to us for review.

In the June 2002 proposed rule (67 FR 43856), we indicated our intent to review the information forwarded by the RUC and all comments we received during the comment period.

Comment: The ASA commented that, based on work values accepted by the RUC anesthesia workgroup, the final RUC data show that anesthesia services are undervalued by a weighted average of 13.57 percent. The ASA urged us to adjust the anesthesia CF accordingly. The American Association of Nurse Anesthetists (AANA) endorsed the ASA's comments and provided similar comments. Several certified registered nurse anesthetists and anesthesiologists also wrote in support of an increase in the anesthesia CF. We also received several comments alleging that the ratio of Medicare payment to private payer payments for anesthesia services is considerably less than the analogous ratio for medical and surgical services.

Response: The ASA and the AANA have requested that we apply the RUC's analysis of the 19 codes to all anesthesia codes. They believe that the weighted average increase in anesthesia work values that results from the RUC's analysis is representative of work values for all other anesthesia codes.

For some codes, the RUC seemed confident that the anesthesia work value of the surveyed code was similar to the anesthesia work values for all of the other surgical services assigned to the given anesthesia code. However, for almost half of the surveyed codes, the RUC did not have confidence that the work values of the surveyed code could be applied to any other anesthesia services that would be reported under that anesthesia code.

Due to the uncertainty of the RUC with regard to extrapolation, even within the family of surgical procedures assigned to a single anesthesia code, we have weighted each of the 19 anesthesia codes only by the anesthesia allowed charges associated with the single surveyed surgical procedure. Using this methodology, anesthesia for the surveyed surgical codes account for approximately 23 percent of all anesthesia allowed charges. This results in an increase in anesthesia work for the 19 codes of 9.13 percent. However, because we will apply a payment

increase only to these codes, we are increasing the physician work portion of the anesthesia conversion factor by 2.10 percent which reflects a 9.13 percent increase in payment applied to the 23 percent of total anesthesia charges represented by the 19 codes. We provide more detail on how this increase is applied to the anesthesia conversion factor in the section VIII of this final rule.

Final Decision

We are increasing the physician work component of the anesthesia conversion factor by 2.10 percent to reflect a 9.13 percent increase in payment applied to 23 percent of anesthesia allowed charges. This as an interim adjustment that is subject to comment.

2. Add-On Anesthesia Codes

Payment for anesthesia services is based on the sum of an anesthesia code-specific base unit value plus anesthesia time units multiplied by an anesthesia CF. Under our current policy at § 414.46(g), if the physician is involved in multiple anesthesia services for the same patient during the same operative session, payment is based on the base unit assigned to the anesthesia service having the highest base unit value and anesthesia time that encompasses the multiple services.

Claims processing manuals instruct the carrier on the method for handling anesthesia associated with multiple or bilateral surgical procedures. Under the Medicare Carrier Manual (MCM) 4830 D, the physician reports the anesthesia procedure with the highest base unit value with the multiple procedures modifier-51 and total time of anesthesia for all surgical procedures. Thus, the carrier is recognizing payment for one anesthesia code.

In CYs 2001 and 2002, the CPT included new add-on anesthesia codes. The objective is that the add-on code would be billed with a primary code, each code having base units. We believe that anesthesia add-on codes should be priced differently from other multiple anesthesia codes. We proposed to revise the regulations at § 414.46(g) to include an exception to the usual multiple anesthesia services policy for add-on codes.

Comment: The ASA, AANA and the AMA expressed support for our adopting a payment policy for add-on anesthesia codes. The ASA asked that we clarify the policy for recognition of base or time units or both for add-on anesthesia codes.

Response: Of the 259 anesthesia codes, there are two codes, called primary codes that may have add on

codes, under certain circumstances. These are:

Primary code: CPT code 01967
Add-on code: CPT code 01968 or 01969
Primary code: CPT code 01952
Add-on code: CPT code 01953

Based on comments received, we understand that the ASA is seeking to bill only the base unit of the add-on code (01953) when it is billed with the primary code 01952. The time of the add-on code is to be included in the time of the primary code. Thus, all anesthesia time is attributable to the primary code.

The ASA is seeking to bill both the base and time of the add-on code, 01968 or 01969, when either is billed with the primary code 01967. Thus, the anesthesia provider would report the base and time units of both the primary and the add-on code.

We recognize that the general policy for add-on codes is that the carrier should allow only the base unit of the add-on code. As with multiple anesthesia services, the anesthesia time of the add-on code would be reported with the time of the primary code. In other words, anesthesia time is reported for all the underlying surgical services.

However, in discussions with the ASA, we have learned that many third party payors have more restrictive time units policies for obstetrical anesthesia codes than for other anesthesia codes. If the time of the add-on code, such as 01968 or 01969, were reported with the primary code, the time units of the add-on code might be undervalued. To prevent this result, we are requiring that (for the two obstetrical anesthesia add-on codes) the anesthesia time be separately reported with each of the primary and the add-on code based on the amount of time appropriately associated with either code.

Further, we think the policy on multiple procedure codes as well as add-on codes is an operational policy and should be addressed only in program operating instructions. As a result, we are revising the regulation text at § 414.46(g) accordingly.

Final Decision

We are allowing the carriers to recognize the base unit of the add-on codes. However, for the obstetrical add-on codes, the carrier may recognize both the base unit and the anesthesia time associated with the add-on code.

C. Pricing of Technical Components (TC) for Positron Emission Tomography (PET) Scans

Currently, all components of HCPCS code G0125, *Lung image PET scan*, are

nationally priced. However, the TC and the global value for all other PET scans are carrier-priced. To keep pricing consistent with other PET scans, we proposed to have carriers price the TC and global values of HCPCS code G0125.

Comment: We received comments from one specialty organization in support of carrier pricing. We received comments from another specialty organization and a few providers stating that they were concerned that, contrary to our stated purpose, this change would lead to inconsistent payment by carriers. The commenters believe that some carriers use the nationally-established TC RVUs for G0125 as a reference for payment for the other PET scans.

Response: While we understand the commenter's concerns, we believe the RVUs assigned before CY 2003 for the TC of G0125 do not accurately reflect the resources used for furnishing this service, which is why we proposed carrier pricing. Thus, using G0125 as a reference code for pricing could lead to inappropriate pricing for all services. We believe that adopting carrier-pricing, instead of a national fee schedule amount, for the TC of G0125 will result in more appropriate pricing for the TC of all PET scans. Carriers have a variety of methods that they use to establish payment for codes. We believe using some of these alternative methods will lead to more accurate pricing for this service.

Final Decision

We will finalize our proposal to allow carriers to price the TC and global values of code G0125.

D. Enrollment of Physical and Occupational Therapists as Therapists in Private Practice

In the November 2, 1998 final rule (63 FR 58814), we defined private practice for physical therapists (PTs) or occupational therapists (OTs) to include a therapist whose practice is in an—

- Unincorporated solo practice;
- Unincorporated partnership; or
- Unincorporated group practice.

The term "private practice" also includes an individual who is furnishing therapy services as an employee of one of the above, a professional corporation, or other incorporated therapy practice. Some carriers and fiscal intermediaries have interpreted the regulation to mean that OTs and PTs employed by physicians cannot be enrolled as therapists in private practice. In these carrier areas, therapy services provided in a

physician's office must instead be billed as incident to a physician's service.

A specialty society representing OTs has requested that carriers be able to enroll OTs in physician-directed groups as OTs in private practice. A group representing PTs believes that provider numbers should be issued only to PTs working as employees in practices owned and operated by therapists.

We proposed to clarify national policy and revise §§ 410.59 and 410.60 to state we would allow enrollment of therapists as PTs or OTs in private practice when employed by physician groups. We believe that this reflects actual practice patterns, will permit more flexible employment opportunities for therapists and will also increase beneficiaries' access to therapy services, particularly in rural areas.

Comments: We received many comments from associations, specialty groups, therapists, and the public that strongly support the proposed clarification that would allow carriers and fiscal intermediaries to enroll therapists as PTs or OTs in private practice when they are employed by physician groups. However, one association urged us to confirm that this policy extends to therapists employed by a non-professional corporation.

Response: We agree and will change the regulation to reflect that carriers and fiscal intermediaries can enroll therapists as PTs or OTs in private practice when the therapist is employed by physician groups or groups that are not professional corporations, if allowed by State law.

Comments: Several commenters suggested that we state clearly that carriers and fiscal intermediaries are required to enroll physician-employed therapists, who are otherwise qualified, and that carriers and fiscal intermediaries may not refuse to enroll therapists simply on the basis of employment. They requested that the regulation state specifically that Medicare contractors must enroll therapists as PTs or OTs in private practice when they are employed or under contractual relationships with physician groups or groups that are not professional corporations.

Response: We agree and will change the Medicare Carriers and Fiscal Intermediaries Manuals' to reflect that carriers and fiscal intermediaries "will" enroll Medicare therapists as PTs or OTs in private practice for purposes of Medicare when the therapists are employed by physician groups or groups that are not professional corporations. However, we do not believe that we need to specify further employee-employer relationships,

which are detailed in the Medicare Carriers Manual, Part 3, Chapter III.

Comment: One commenter believed that we should not enroll PTs who are employees of physicians' offices as PTs or OTs in private practice but, instead, should establish a separate section of the regulations that would govern the issuance of provider numbers to PTs who are employees in physicians' offices, and give these therapists a different designation. The commenter suggested we also include protections that currently exist when a non-physician practitioner provides services in a physician's office and the physician bills for these services under the physician's Medicare provider number.

Response: We disagree with this comment. We have established procedures for issuing provider numbers that we believe are adequate. The proposed changes to the regulations reflect actual practice patterns, will permit more flexible employment opportunities for all therapists, and also increase beneficiary access to therapy services, particularly in rural areas. Therapists still have the flexibility of providing outpatient therapy services incident to a physician's service if they so choose. However, the services must meet the incident to requirements at § 410.26.

Final Decision

We will finalize our proposal to revise §§ 410.59 and 410.60 with the modifications noted above.

E. Clinical Social Worker Services

In the June 28, 2002 proposed rule, (67 FR 43846), we indicated we would be addressing comments received on the October 19, 2000 proposed rule entitled, "Clinical Social Worker Services," (65 FR 62681), in this final rule. Upon further review, we have determined that we will not include this issue in this final rule, but will address it in future rulemaking.

F. Medicare Qualifications For Clinical Nurse Specialists

Currently, the qualifications for a clinical nurse specialist (CNS) include a requirement that a CNS must be certified by the American Nurses Credentialing Center (ANCC). We proposed to revise this particular requirement under the CNS qualifications because of concerns expressed that the ANCC does not provide certification for CNSs who specialize in fields such as oncology, critical care, and rehabilitation. Additionally, we noted that the proposed revision of the certification requirement for CNSs is consistent with

the certification requirement under the nurse practitioner (NP) qualifications. Accordingly, we proposed specifically to revise section § 410.76(b)(3) to read as follows:

“Be certified as a clinical nurse specialist by a national certifying body that has established standards for clinical nurse specialists and that is approved by the Secretary.”

Comments and Responses

We received comments on the proposed revision to the CNS certification requirement from professional nursing societies, a specialty nursing certification corporation, a college of radiology, a major nurses association, a provider of health care and elder care and, several independent clinical nurse specialists.

Comment: We received comments indicating that the current CNS certification requirement poses a serious threat to ensuring Medicare beneficiary access to quality care because it restricts CNSs who are not certified by the ANCC from qualifying for Medicare payment. The ANCC does not certify CNSs in oncology, rehabilitation, acute care or critical care. Since the current CNS certification requirement inherently precludes CNSs who are certified in oncology from Medicare payment, the number of nurses available to care for Medicare beneficiaries with cancer is limited. The proposed change to the CNS qualifications is more inclusive, and it will enable the 415 oncology CNSs who hold Advanced Oncology Nursing Certification (AOCN) provided by the Oncology Nursing Certification Corporation (ONCC) to meet the certification criteria for CNSs and therefore, qualify for Medicare payment. An independent CNS stated that as a palliative care CNS, her institution required advanced certification that is not offered by the ANCC in many specialty areas of practice. However, the American Board of Nursing Specialties is the credentialing board for the ONCC, which is the only national certification that an advanced practice nurse can obtain specific to his or her field of expertise. All of the commenters support the proposed revision to the CNS certification requirement because they stated that overall, the certification criteria for CNSs will be consistent with the certification criteria for NPs and the requirement will ensure that Medicare beneficiaries receive services from advanced practice nurses who are certified by a national certifying body.

Response: It has not been our intention to be overly restrictive in our program requirements and consequently prevent qualified CNSs who specialize

in areas of medicine other than those certified by the ANCC from participating under the Medicare program's CNS benefit and rendering care to patients in need of specialized services. The intent of the revised CNS certification requirement is to recognize all appropriate national certifying bodies for CNSs as the program does for NPs.

Result of Evaluation of Comments

We are implementing the proposed revision to the CNS certification requirement under the CNS qualifications at § 410.76.

G. Process To Add or Delete Services to the Definition of Telehealth

In the June 2002 proposed rule (67 FR 43862), we proposed to establish a process for adding or deleting services from the list of telehealth services, and to add specific services to the list of telehealth services for CY 2003.

We stated that we would accept proposals from any interested individuals or organizations from either the public or the private sectors, for example, from medical specialty societies, individual physicians or practitioners, hospitals, and State or Federal agencies. We also mentioned that we might internally generate proposals for additions or deletions of services.

We stated that we would post instructions on our website outlining the steps necessary to submit a proposal. Please see the June 2002 proposed rule for the items that were to be addressed, the assignment of categories, and the outcomes.

We proposed to remove a service from the telehealth list of services if, upon review of the available evidence, we determine that a telehealth service is not safe, effective, or medically beneficial when performed as a telehealth service.

We proposed to make additions or deletions to the list of telehealth services effective on a CY basis. We proposed to use the annual physician fee schedule proposed rule published in the summer and the final rule published by November 1 each year as the vehicle for making these changes. Requests must be received no later than December 31 of each CY to be considered for the next proposed rule.

Based upon further review of the comments submitted in response to the proposed rule for CY 2002, we believe that the psychiatric diagnostic interview is similar to the telehealth services listed in the statute. Specifically, we believe this service would meet the criteria set forth in Category 1 of the proposed process for adding services.

Therefore, we proposed to add psychiatric diagnostic interview examination as represented by CPT code 90801 to the list of telehealth services and proposed to revise §§ 410.78 and 414.65 to reflect the proposed addition to the list of telehealth services.

Comment: We received many comments expressing support for our proposed process for adding and deleting telehealth services. The commenters indicated that our proposed criteria for reviewing submitted requests are reasonable and provide a viable mechanism for adding existing services to the list of telehealth services. However, as part of our review, one specialty college suggested that the CPT editorial panel be an integral part of our process. The commenter stressed that reviewing codes and determining how these services can be furnished is the CPT editorial panel's area of expertise. With regard to deletion of services, one association urged us to consult with the appropriate medical society members to obtain clinical evidence based on peer-reviewed information and medical journal articles before deleting services from the list of telehealth services.

Response: Section 1834(m) of the Act requires us to develop a process specifically for adding or deleting telehealth services on an annual basis. The mandate for this statutory provision is separate and distinct from the role of the AMA CPT editorial panels in developing new codes and/or defining services for the CPT compendia. It would not be appropriate to make the CPT editorial panel an integral part of the process to add or delete services from the list of telehealth services. We will review submitted requests for addition and deletion based on the criteria discussed in this final rule and welcome input from medical professionals with expertise in the service being reviewed as part of the rulemaking process.

We are clarifying from the proposed rule that a decision to remove a service from the list of telehealth services would be made using evidence-based, peer-reviewed data which indicate that a specific telehealth service is not safe, effective, or medically beneficial. Such determination would not be made under section 1862(a)(1)(A) of the Act. Therefore, a decision to delete a service under this process would only apply to the list of Medicare telehealth services.

Comment: One commenter suggested that we publish a summary of any requests that are rejected.

Response: As stated in the proposed rule, we will use the annual physician fee schedule as a vehicle to make changes to the list of telehealth services.

As part of the rulemaking process, we will publish a summary in the proposed rule of the requests that we receive with an explanation as to why a service is added, deleted, or a request is rejected.

Comment: One commenter requested that, if possible, we look for ways to shorten the time frame between the submittal of a request and the actual implementation. The commenter stated that actual implementation of an additional telehealth service could take a year or more from the date of the request.

Response: The statute requires us to establish a process that provides for the addition or deletion of telehealth services on an annual basis. We understand that in some cases our review and subsequent implementation of a decision to accept a request may take up to and possibly more than a full year. However, we believe that using the annual physician fee schedule rulemaking schedule would be the most efficient and time sensitive mechanism for publishing changes to the list of telehealth services.

A national coverage determination (NCD) is a possible alternative to the rulemaking process for adding or deleting telehealth services. In formulating the proposed process to add services to the list of telehealth services, we considered using the NCD process. For instance, under this option, all requests for addition, whether the request is considered an existing or new service, would be required to complete the requirements for an NCD. We rejected this option because we believe that many telehealth applications are existing services provided through a different delivery mechanism. We believe that subjecting all requests for addition to the evidence-based requirements of an NCD would be unnecessary, and would be contrary to the public interest.

Comment: A large number of commenters applauded the addition of the psychiatric diagnostic interview examination to the list of telehealth services. Commenters generally agreed that the psychiatric diagnostic interview includes components that are comparable to an initial office visit or consultation, which are currently telehealth services.

Response: We agree with the comment.

Comment: We received two comments regarding general telehealth policy. One commenter urged us to expand the definition of an originating site. For example, the commenter believes that hospitals with inadequate physician ratios relative to the treatment of acute ischemic stroke patients should be

considered as an originating site, regardless of geographic location or whether the hospital is located in a designated health professional shortage area. The other comment pertained to the physician or practitioner who provides the telehealth service at the distant site. In this regard, one association encouraged us to support the addition of speech language pathologists and audiologists to the list of practitioners that may provide and receive payment for telehealth services.

Response: The statute permits hospitals to serve as originating sites for any Medicare telehealth service as long as the hospital is located in a rural HPSA or in a non-MSA county. Thus, the commenter would be able to serve as an originating site for the treatment of acute ischemic stroke patients if the hospital is located in these geographic areas. The statute is explicit regarding the types of practitioners who can provide and receive payment for telehealth services. Speech language pathologists and audiologists are not included within the list of medical professionals that may provide and or receive payment for telehealth services at the distant site. We are reviewing these issues as part of a report to the Congress as required by the BIPA.

Result of Evaluation of Comments

We are adopting the process to add or delete telehealth services and adding the psychiatric diagnostic interview examination to the list of telehealth services as stated in the proposed rule. Additionally, we are referencing the process to add or delete services at new § 410.78(f).

H. Definition for ZZZ Global Periods

Services with ZZZ global periods are add-on services that can be billed only with another service. Before CY 2003, we paid only the incremental intraservice work and practice expense RVUs associated with the add-on service for a code with a global indicator of ZZZ. Any pre-service or post-service work associated with a service with a global indicator of ZZZ is considered accounted for in the base procedure with which these add-on services must be billed. However, based on comments from the RUC and specialty societies that some add-on services contain separately identifiable post-service work and practice expense RVUs, we proposed to revise the current definition of a ZZZ global period as follows:

“ZZZ = Code related to another service and is always included in the global period of the other service (Note: Physician work is associated with intra-

service time and in some instances the post-service time).”

Comments: The commenters supported this change. However, several specialty organizations, as well as the RUC, stated that there are instances when pre-service time should be considered, and they recommended that we amend the definition to include pre- and post-service time.

Response: We agree with the commenters and will revise the definition to consider pre-service time as well post-service time. However, when a code with a ZZZ global indicator is considered by the RUC or PEAC, we will require that all base codes with which the ZZZ codes are billed are also considered by the RUC and PEAC to assure that both physician work and practice expense RVUs are appropriate for the base and add-on codes and to assure that no duplicate payment is made.

Result of Evaluation of Comments

The definition of a ZZZ global period will be revised as follows:

“ZZZ = Code related to another service and is always included in the global period of the other service (Note: Physician work is associated with intraservice time and in some instances the pre- and post-service time).”

I. Change in Global Period for CPT Code 77789 (Surface Application of Radiation Source)

Based on a suggestion from the RUC, we proposed to change the global period for CPT code 77789 (surface application of radiation source) from a 90-day global period to a 000-day global period. We stated that we did not need to adjust the current work values or the practice expense inputs for supplies and equipment, but we would adjust the clinical staff practice expense inputs to reflect that there is no post-procedure visit.

Comment: The commenters supported this change and noted that the PEAC attributed clinical times for this CPT code of 34 minutes for the registered nurse and 6 minutes for the physicist. The commenters did not believe the practice expense RVUs should change significantly, if at all, as a result of this adjustment in the global period.

Response: We had not received the PEAC recommendations at the time the proposed rule was written, and we proposed a change to the original CPEP inputs that included time for a post-procedure visit. We have reviewed and accepted the above PEAC recommended clinical staff times.

Result of Evaluation of Comments

We are changing the global period for CPT code 77789 (surface application of radiation source) from a 90-day global period to a 000-day global period as proposed.

J. Technical Change for § 410.61(d)(1)(iii) Outpatient Rehabilitation Services

Based on comments received that § 410.61(d)(1)(iii) incorrectly references "physical" therapy when it should reference "occupational" therapy, we proposed to revise § 410.61(d)(1)(iii) to correct this error.

Final Decision

No comments were received on this proposed technical correction. We will correct § 410.61(d)(1)(iii) by replacing the word "physical" with "occupational" as proposed.

K. HCPCS G-Codes From June 28, 2002 Proposed Rule

In the June 28, 2002 rule we proposed the following new HCPCS G codes.

1. Codes for Treatment of Peripheral Neuropathy

Effective for services furnished on or after July 1, 2002, Medicare will cover an evaluation (examination and treatment) of the feet every six months for individuals with a documented diagnosis. This policy is a national coverage determination.

G0245: Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include the procedure used to diagnose LOPS; a patient history; and a physical examination that consists of at least the following elements—

- (a) Visual inspection of the forefoot, hindfoot and toe-web spaces;
- (b) Evaluation of protective sensation;
- (c) Evaluation of foot structure and biomechanics;
- (d) Evaluation of vascular status and skin integrity;
- (e) Evaluation and recommendation of footwear; and
- (f) Patient education.

We proposed to crosswalk work and malpractice RVUs and the practice expense inputs from CPT code 99202, a level two, new patient office visit code. We proposed to revalue the practice expense RVUs using the practice expense methodology once we have utilization data for these codes.

G0246: Follow-up evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following, a patient history

and physical examination that includes—

- (a) Visual inspection of the forefoot, hindfoot and toe-web spaces;
- (b) Evaluation of protective sensation;
- (c) Evaluation of foot structure and biomechanics;
- (d) Evaluation of vascular status and skin integrity;
- (e) Evaluation and recommendation of footwear; and
- (f) Patient education.

We proposed to crosswalk the work and malpractice RVUs from CPT code 99212, a level two, established-patient office visit code. We also proposed to crosswalk the practice expense inputs from CPT code 99212 and to revalue the practice expense RVUs using the practice expense methodology once we have utilization data for these codes.

G0247: Routine foot care of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following—

- (a) Local care of superficial wounds;
- (b) Debridement of corns and calluses; and
- (c) Trimming and debridement of nails.

We proposed to crosswalk the work and malpractice RVUs and the practice expense inputs from CPT code 11040, *Debridement; skin; partial thickness*. We would revalue the practice expense RVUs using the practice expense methodology once we have utilization data for this code.

Comment: The American Podiatric Medical Association (APMA) believes that the RVUs assigned to HCPCS codes G0245 and G0246 are too low. They do not believe that the assigned RVUs account for the physician work and practice expense required to perform those services. They recommended that we crosswalk the RVUs from CPT codes 99203 and 99213 to these codes instead of the crosswalk we actually used, from CPT codes 99202 and 99212. They also commented that the RVUs assigned for G0247 were too low and should be increased as the assigned RVUs did not account for the required physician work. Alternatively, they recommended that we delete G0247 and allow a physician to report CPT codes that described similar services. A large medical clinic commented that they were not sure why CMS had implemented these codes. They believe that if the only reason for creating codes was to permit us to track the services, this reason is insufficient because the codes cause significant administrative burden to physician practices. They believe that providers could use other CPT codes to report these services

instead of the G codes. A carrier medical director familiar with these services commented that G0247 is overvalued because the most common service provided using this code will be toe nail trimming and debridement and that the CPT code for toe nail trimming and debridement is valued much lower than G0247.

Response: These G codes were created to implement a national coverage determination (NCD). The coverage determination was very specific with regard to the required components of each service. Furthermore, the NCD specifically allowed these services to be performed no more than every six months and allowed the initial visit to be performed only once per physician for the lifetime of a beneficiary. Creation of these G codes allows us to implement the coverage decision, especially with regard to the required frequency limitation and to track the utilization of these services while minimizing provider burden. Reporting these services with CPT evaluation and management (E/M) codes and procedure codes would have resulted in numerous post-pay audits while creation of a modifier to be used in conjunction with such CPT codes would have been quite burdensome and resulted in just as many post pay audits. Therefore, we plan to continue requiring these G codes for reporting of these services.

With regard to the valuation of these services we will finalize the proposed RVUs. This service is provided to those diabetic beneficiaries who are "at risk" for foot-care problems but who do not have an injury or illness of the foot. Any service provided to a diabetic beneficiary with an illness or injury to the foot (for example, foot pain, foot ulcer, foot infection) should be reported using the appropriate CPT codes (for example, E/M service, debridement service). Furthermore, the requirements for provision of care to LOPS patients are clearly set forth in the NCD. Nothing beyond those requirements need be performed in order to report a LOPS HCPCS code. Careful scrutiny of the requirements for provision of initial LOPS services shows that they are most similar to the requirements of a level 2 E/M service. The lack of illness, injury, or deformity in these patients and the requirements that the practitioners need only to take a history and to examine the foot are quite similar to the requirements of CPT code 99202: an expanded problem focused history, an expanded problem focused examination, and straightforward medical decision making. For follow-up patients who do not have an illness, injury, or deformity, the requirements of

the NCD are quite similar to the requirements of CPT code 99212: a problem focused history, a problem focused examination, and straightforward medical decision making. With regard to G0247, we agree with the carrier medical director who stated that the most commonly performed procedure would be toenail trimming and/or debridement. However, review of the work RVUs for CPT codes 11719 (0.17), 11720 (0.32), 11721 (0.54), 11055 (0.43), 11056 (0.61), 11057 (0.79), and 11040 (0.50) shows that we have properly valued this service. We believe that a work value of 0.50 RVUs appropriately accounts for what is likely to be the typical combination of services provided to eligible beneficiaries.

Result of Evaluation of Comments

We will continue requiring these G codes for reporting of these services and are finalizing the RVUs as proposed.

2. Current Perception Sensory Nerve Conduction Threshold Test (SNCT)

G0255: Current Perception Threshold/Sensory Nerve Conduction Test, (SNCT) per limb, any nerve

We proposed a G-code that represents SNCT as a diagnostic test used to diagnose sensory neuropathies. This test is noninvasive and uses a transcutaneous electrical stimulus to evoke a sensation. However, we determined that there is insufficient scientific or clinical evidence to consider the use of this device as reasonable and necessary within the meaning of section 1862(a)(1)(A) of the Act and indicated Medicare will not pay for this type of test.

Comment: One commenter requested that the descriptor for this code be revised, as the current descriptor "Current Perception Threshold/Sensory Nerve Conduction Test" is very similar to other codes for example, the short descriptor for CPT code 95904 is "Sense Nerve Conduction Test". The commenter recommended changing the descriptor for this G code to "Current Perception Threshold Test".

Response: We appreciate the commenters bringing this to our attention and have revised the short descriptor for this G code to address the concern they raised. The short descriptor for this G code will be "Current perception threshold test".

Result of Evaluation of Comments: We will finalize our proposal for G0255 but will revise the short descriptor as discussed above.

3. Positron Emission Tomography (PET) Codes for Breast Imaging

Medicare has expanded the coverage indications for PET scanning to include

imaging for breast cancer, and we have created codes that describe staging and restaging after or prior to the course of treatment of breast cancer. We also created a PET scan code to evaluate the response to treatment of breast cancer.

PET imaging for initial diagnosis of breast cancer and/or surgical planning for breast cancer are described by a CPT code, but Medicare will not cover the procedure for this diagnosis.

G0252: PET imaging for initial diagnosis of breast cancer and /or surgical planning for breast cancer (for example, initial staging of axillary lymph nodes), not covered by Medicare.

We stated that this code is not covered by Medicare because there is a national non-coverage determination for the use of PET imagery for the initial diagnosis of breast cancer and initial staging of axillary lymph nodes.

G0253: PET imaging for breast cancer, full and partial-ring PET scanners only, staging/restaging after or prior to course of treatment.

G0254: PET imaging for breast cancer, full and partial-ring PET scanners only, evaluation of response to treatment, performed during course of treatment.

We proposed that the TC and global for both of these codes be carrier-priced. For the PC for codes G0253 and G0254, we proposed to make the PC work RVU equal to 1.87 and use practice expense RVUs of 0.58 and malpractice RVUs of 0.07 since there are no direct inputs for PC services.

Comments: Commenters expressed appreciation for creation of these G codes; however, one commenter was concerned that the TC and global component of these codes will be carrier-priced which, the commenter contended, could lead to widely varying and unjustifiably low payment rates, particularly if there is no national benchmark.

Response: Carriers use a variety of methods and resources when developing payment rates for services that they are responsible for pricing. We do not believe that having the carriers price these codes will lead to unjustifiably low payment rates.

Result of Evaluation of Comments: We are adopting the proposals for these G codes; however, we have made editorial revisions to the descriptors for G0252 and G0253 to more accurately describe the service provided. The revised descriptors are as follows:

G0252: PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and /or surgical planning for breast cancer (for example, initial staging of axillary lymph nodes).

G0253: PET imaging for breast cancer, full and partial-ring PET scanners only, staging/restaging of local regional recurrence or distant metastases (that is, staging/restaging after or prior to course of treatment).

4. Home Prothrombin Time International Normalized Ratio (INR) Monitoring for Anticoagulation Management

For services furnished on or after July 1, 2002, Medicare will cover the use of home prothrombin time or INR monitoring in a patient's home for anticoagulation management for patients with mechanical heart valves. A physician must prescribe the testing. The patient must have been anticoagulated for at least three months prior to use of the home INR device, and the patient must undergo an education program. The testing with the device is limited to a frequency of once per week.

G0248: Demonstration, at initial use, of home INR monitoring for a patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstration use and care of the INR monitor, obtaining at least one blood sample provision of instructions for reporting home INR test results and documentation of a patient's ability to perform testing.

We proposed that this code be assigned no work RVUs and .01 malpractice RVUs. For the practice expense inputs, we proposed 75 minutes of RN/LPN/MTA staff time; a supply list including four test strips, lancets and alcohol pads, a patient education booklet, and batteries for the monitor; and equipment consisting of a home INR monitor. These proposed inputs result in an estimated practice expense RVU of 2.92.

G0249: Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria. Includes provision of materials for use in the home and reporting of test results to physician; per 4 tests.

We proposed this code be assigned no work RVUs and .01 malpractice RVUs. For the practice expense inputs, we proposed 13 minutes of RN/LPN/MTA staff time; a supply list including four test strips, lancets and alcohol pads, and equipment consisting of a home INR monitor. These resulted in an estimated practice expense RVU of 2.08.

G0250: Physician review/interpretation and patient management of home INR test for a patient with mechanical heart valve(s) who meets other coverage criteria; per 4 tests (does not require face-to face service)

We proposed this code be assigned 0.18 work RVUs and .01 malpractice RVUs. We stated that there would be no direct practice expense inputs for this code, and the use of the practice expense methodology to develop the indirect practice expense of the physician performing this service resulted in an estimated practice expense RVU of 0.07. Note: Subsequent to the publication of the proposed rule, we updated the payment rates for home PT/INR monitoring via Program Memorandum AB-02-112 (July 31, 2002). Based on a correction in the practice expense methodology used to calculate the practice expense RVUs issued in the Program Memorandum AB-02-064 on May 2, 2002 and included in the June 28, 2002 proposed rule there was an increase in practice expense RVUS for G0248 to 3.06 and to 3.28 for G0249 effective for services performed after October 1, 2002.

Comment: A manufacturer of equipment used to perform INR monitoring at home was concerned that the proposed RVUs for the HCPCS codes used to report Home INR monitoring services were inconsistent with the RVUs published in Program Memorandum AB-02-112 issued on July 31, 2002. (This program memorandum was issued to correct an error that had resulted in the original RVUs for these codes being too low.) The commenter also requested that we clarify the descriptor for the HCPCS code used to report provision of Home INR materials to assure that Medicare only paid for properly controlled INR tests that were consistent with FDA labeling.

Response: The aforementioned program memorandum was issued after the Proposed Rule (NPRM) was published. We agree with the commenter that the physician fee schedule for 2003 should reflect the RVUs as published in the July 31, 2002 program memorandum and will make this change.

With regard to changing the descriptors for the HCPCS code used to report provision of home INR test materials, we will review this issue and, if appropriate, clarify the descriptor as requested for CY 2004.

Comment: Several commenters asked CMS to expand the covered indications for home INR monitoring.

Response: We direct these commenters to the published process for requesting a national coverage determination. In order for the covered indications to be expanded on a national level this process must be followed.

Comment: A manufacturer of equipment used for home INR monitoring pointed out that there were several companies who manufacture test strips. Producing a test result may require one or three test strips depending on the manufacturer. Additionally, the cost of test strips from each manufacturer is different and Medicare based its payment on the cost of a test strip from only one manufacturer.

Response: We agree that there are several types of test strips available. However, we also understand that not all manufacturers are currently providing new home INR monitoring equipment and that the market share for each product is in flux. We will review the appropriate payment for this service, including the appropriate amount to include for test strips, after we have sufficient experience paying for this service. The earliest time that we could consider proposing a change in payment rate would be for the 2005 physician fee schedule; at that time, we would have 18 months worth of payment data upon which we could base a proposal.

Result of Evaluation of Comments

As indicated above, payment for CY 2003 for these services will reflect the corrections made in the Program Memorandum AB-02-112 issued on July 31, 2002.

5. Bone Marrow Aspiration and Biopsy on the Same Date of Service

We proposed a new G code (GXXXX) that reflects a bone marrow biopsy and aspiration procedure that is performed on the same date, at the same encounter, through the same incision, based on our understanding that the typical case involves an aspiration and biopsy through the same incision.

We proposed physician work RVUs of 1.56 and malpractice RVUs of 0.04. We also proposed to crosswalk the practice expense inputs from CPT code 38220, Bone marrow aspiration, with the assignment of an additional five minutes of clinical staff time. These proposed inputs in the practice expense methodology resulted in an estimated practice expense RVU of 3.32 in the nonfacility setting and 0.60 in the facility setting.

We also noted that if the two procedures, aspiration and biopsy, are performed at different sites (for example, contralateral iliac crests, sternum/iliac crest, two separate incisions on the same iliac crest or two patient encounters on the same date of service), the CPT codes for aspiration and biopsy would each be used along with the -59 modifier.

Comment: Two commenters, one representing a provider and the other a specialty organization, agreed with the proposal to create a G code for bone marrow aspiration and biopsy on the same date of service. However, another specialty organization and the AMA did not agree with the creation of this new G code and felt its creation was unnecessary. These commenters indicated that CPT currently has sufficient and accurate coding for these services that is, CPT codes 38220 and 38221 which when performed through the same incision could both be reported with the modifier 51 (used in reporting of multiple procedures performed in the same incision) appended. In addition, the commenters stated that the descriptor for this code does not adequately describe the procedure for which it is intended as it does not specifically state "through the same incision." This could lead to a denial of services of all bone marrow aspiration and biopsies performed on the same date of service.

Response: After review of the comments, we agree that this code should go through the CPT process. Therefore, we are withdrawing our proposal to create this code. We will submit a code for "Bone Marrow Biopsy and Aspiration performed in the same bone" to CPT in time for the 2004 CPT cycle.

Result of Evaluation of Comments

We will not proceed with a separate G code for bone marrow biopsy and aspiration procedure that is performed on the same date, at the same encounter.

Creation of G Codes

Comment: Several commenters expressed concern about the increasing frequency of G codes being issued by us. Commenters believed that, in the interest of coding standardization, accuracy, and clarity, G codes should only be developed as a last resort and should be temporary. Commenters believed that an annual meeting with us to discuss codes that may be necessary to accommodate new payment and coverage policies would help reduce the number of G codes. Some commenters also asked for greater physician involvement in the HCPCS editorial process (for example, direct representation of the physician community on the panel).

Response: We agree that, where appropriate, G codes should be temporary. Unfortunately, it is sometimes necessary to develop G codes to accommodate changes in legislation, regulation, coverage, and payment policy. The timetable for such changes

is not necessarily consistent with the timetable for CPT publication and frequently these changes must be made on a quarterly basis.

In 2002 CMS and CPT staff, working together, reviewed all existing G codes and agreed to transition over 20 of them to CPT codes. Therefore, for 2003 many G codes are being deleted in favor of newly created CPT codes. (See section IV for a discussion of deleted G codes). We believe that an annual review of G codes by CMS and CPT staff is the best way to determine which G codes should be transitioned to CPT codes and the process to use for such a transition. Therefore, we plan to continue working with CPT staff on an annual basis to continue transitioning existing G codes to CPT codes. We believe such an annual comprehensive review will address the commenters' concerns. However, we do wish to emphasize that we, when appropriate, does consult with interested providers prior to the creation of G codes in order to facilitate coding clarity and minimize physician burden.

L. Endoscopic Base For Urology Codes

Cystoscopy and treatment CPT codes 52234, 52235, and 52240 were inadvertently identified in the Medicare Physician Fee Schedule Database as services subject to the reductions for multiple procedures as opposed to the procedural reduction rules specific to endoscopic services. This has resulted in our overpaying for these services. We proposed applying the endoscopic reduction rules to these services and identified CPT code 52000 as the endoscopic base code for these services.

Comment: The American Urological Association was in agreement with our proposal to apply the endoscopic reduction rules to CPT codes 52234, 52235, and 52240.

Final Decision: The endoscopic reduction rules will be applied to these three codes as proposed.

M. Physical Therapy and Occupational Therapy Caps

Section 4541(c) of the Balanced Budget Act of 1997 required application of a payment limitation to all rehabilitation services provided on or after January 1, 1999. The limitation was an annual per beneficiary limit of \$1500 on all outpatient physical therapy (PT) services (including speech-language pathology services). A separate \$1500 limit was applied to all occupational therapy (OT) services. (The limitation amounts were to be increased to reflect medical inflation.) The annual limitation did not apply to services furnished directly or under arrangement

by a hospital to an outpatient or to an inpatient who is not in a covered Part A stay.

Section 221 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113, enacted on November 29, 1999) placed a moratorium on the application of the payment limitation for two years from January 1, 2000 through December 31, 2001. Section 421 of the Medicare, Medicaid, and SCHIP Beneficiary Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554, enacted on December 21, 2000), extended the moratorium on application of the limitation to claims for outpatient rehabilitation services with dates of service January 1, 2002 through December 31, 2002. As we explained in the June 28, 2002 proposed rule, outpatient rehabilitation claims for services rendered on or after January 1, 2003 will be subject to the payment limitation unless the Congress acts to extend the moratorium.

Comments: We received comments from associations and societies urging us to support the permanent repeal of the \$1500 financial limitation on PT, including speech language pathology, and a separate \$1500 financial limitation on OT. All commenters stated that this financial limitation would adversely affect nursing home beneficiaries who receive Part B therapy services.

Response: As stated before, we will implement the outpatient rehabilitation therapy financial limitation via a Program Memorandum to Carriers and Fiscal Intermediaries, unless the Congress acts to extend the moratorium or repeals the legislation.

III. Other Issues

A. Definition of a Screening Fecal-Occult Blood Test

One commenter suggested that the current definition of a screening fecal-occult blood test at § 410.37(a)(2) that limits coverage to guaiac-based tests should be expanded to permit coverage of another test. The commenter suggested that this change be made in the final rule because the June 2002 proposed rule added a variety of new HCPCS G codes similar to the G code for which the commenter has requested for its new fecal-occult blood test.

Based on our analysis of the preliminary information we have on the new test, we believe that it may have the potential for effective screening for colorectal cancer, and thus, we have agreed with the commenter to broaden the definition in § 410.37(a)(2) to permit coverage of non-guaiac based tests. However, in order to establish national

coverage of the new test under the Medicare colorectal cancer screening benefit we must first compare the clinical utility of the test to the existing guaiac-based test. If, for instance, the test is not as effective as the currently covered test, it would not make sense to authorize coverage as permitted by section 1861(pp)(1)(D) of the Act.

To facilitate our consideration of future coverage of other new types of fecal-occult blood tests, we have decided to amend § 410.37(a)(2) to provide that in addition to the guaiac-based screening test, other types of fecal-occult blood tests may be covered under the screening benefit, if we determine that this is appropriate through a national coverage determination (NCD). This change will allow us to conduct a more timely assessment of other new types of fecal-occult blood tests that may have been approved or cleared for marketing by the Food and Drug Administration (FDA) than is possible under the standard rulemaking process. We intend to use the NCD process, which includes an opportunity for public comments, for evaluating the medical and scientific issues relating to the coverage of additional tests that may be brought to our attention in the future. Use of an NCD to establish a change in the scope of benefits is authorized by section 1871(a)(2) of the Act.

In accordance with section 1861(pp)(1)(D) of the Act, we have discretion to determine that additional tests or procedures are appropriate and can be used for the early detection of colorectal cancer. This authority is currently reflected in § 410.37(a)(1)(v). We are amending that section to announce that approval of any new tests or procedures for use in early detection of colorectal cancer will be made through an NCD. The use of an NCD, authorized by section 1871(a)(2) of the Act, will permit public participation. The NCD process, however will allow Medicare to expand coverage for additional tests or procedures when warranted more rapidly than the notice and comment procedures of the Administrative Procedure Act would normally permit.

B. Clarification of Services and Supplies Incident to a Physician's Professional Services: Conditions

In the November 2001 final rule (66 FR 55238) we revised regulations on services and supplies furnished incident to a physician's professional services. In the revised regulations at § 410.26(a)(7) we defined such services and supplies as “ * * * any services and supplies * * * that are included in section

1861(s)(2)(A) of the Act and are not specifically listed in the Act as a separate benefit included in the Medicare program.”

We are clarifying that services having their own statutory benefit category are covered under that category rather than as incident to services. This means that they are subject to manual and other program operating instructions pertaining to their specific statutory benefit category. In addition, they are not required to meet incident to implementing instructions such as those in section 2050 of Part III of the Medicare Carriers Manual (MCM). For example, diagnostic tests are covered under section 1861(s)(3) of the Act and are subject to the requirements for diagnostic tests in MCM section 2070. Depending on the particular test, the supervision requirement in section 2070 may be more or less stringent than that in section 2050 for incident to services. When diagnostic tests are furnished, the requirements for diagnostic tests apply, and not those for incident to services. Likewise, pneumococcal, influenza, and hepatitis B vaccines are covered under section 1861(s)(10) of the Act and do not need to meet incident to requirements.

While we believe our regulations are clear on this point, one of the comments and responses published in our November 2001 final rule has caused some confusion on this issue. The comment and response were as follows:

Comment: “Many commenters wanted us to re-emphasize that incident to services set forth in section 1861(s)(2)(A) of the Act do not include Medicare benefits separately and independently listed in the Act, such as diagnostic services set forth in section 1861(s)(3). Some requested that we not permit these separately and independently listed services to be furnished as incident to services.”

Response: “We realize, as did the Congress with the enactment of section 4541(b) of the BBA, that many services—even those that are separately and independently listed—can be furnished as incident to services. However, this fact of medical practice is not inconsistent with our policy. We maintain that a separately and independently listed service can be furnished as an incident to service but is not required to be furnished as an incident to service. Furthermore, even if a separately and independently listed service is provided as an incident to service, the specific requirements of that separately and independently listed service must be met. For instance, a diagnostic test under section 1861(s)(3) of the Act may be furnished as an incident to service. Nevertheless, it

must also meet the requirements of the diagnostic test benefit set forth in § 410.32. Specifically, the test must be ordered by the treating practitioner, and it must be supervised by a physician. Thus, if a test requires a higher level of physician supervision than direct supervision, then that higher level of supervision must exist even if the test is furnished as an incident to service. Accordingly, we decline to prohibit a separately and independently listed service from being furnished as an incident to service. Instead, we reiterate that a separately and independently listed service need not meet the requirements of an incident to service.”

The intent of the above response was to state that for a service having its own separately and independently listed statutory benefit category, Medicare carriers should apply the requirements of that separately listed benefit category and not also apply the incident to requirements. We interpret § 410.26(a)(7) literally. That is, incident to services and supplies covered under 1861(s)(2)(A) of the Act means services and supplies not having their own independent and separately listed statutory benefit category.

Perhaps it could be argued that any service provided under the direct supervision of a physician could be considered an incident to service. However, the Congress specifically provided for the many separate benefit categories of medical and health services in the Act. We believe that the Congress intended for incident to services to be a catch-all category to allow payment for certain services and supplies commonly furnished in a physician's office and not having their own separate benefit category. The billing of services with their own separate and independent coverage benefit categories as incident to may circumvent the coverage and payment rules applicable to those other categories. Therefore, only services that do not have their own benefit category are appropriately billed as incident to a physician service. Examples of benefit categories are diagnostic X-ray tests (section 1861(s)(3) of the Act) and influenza vaccine and its administration (section 1861(s)(10)(A) of the Act).

However, since section 4541(b) of the BBA allows certain services with their own benefit category (that is, outpatient physical therapy services (including speech-language pathology services) and outpatient occupational therapy) to also be provided as incident to services, we cannot prohibit physicians and practitioners from billing these services as incident to. However, when these services are billed incident to,

requirements in Medicare Carriers Manual section 2050 must also be met. Note that the personal (in-the-room) supervision requirements for physical and occupational therapy assistants apply only to the private practice setting. The services of nurse practitioners, clinical nurse specialists and physician's assistants may be billed as incident to a physician's service if the incident to requirements are met, or those practitioners may bill their services separately under their own benefit.

C. Five-Year Review of Gastroenterology Codes

In the November 2001 final rule, (66 FR 55246), we finalized work RVUs for several gastrointestinal endoscopy codes that were reviewed by the RUC during the five-year review of physician work. However, we asked the RUC to review several families of gastrointestinal endoscopy codes to ensure that no rank order anomalies existed within those families. The procedures for gastrointestinal stent placement were among those families. Although we have not received further RUC recommendations for any gastrointestinal endoscopy codes, several specialty societies have submitted further information regarding the physician work required to perform gastrointestinal stent placement services. We have reviewed this information and are making several adjustments to the RVUs for these services. These adjustments are interim and we will respond to comments concerning these adjustments in next year's final rule.

CPT code 43219 Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent

Based on the information we have reviewed (including physician intraservice time data), there is no compelling evidence that the physician work of this procedure is inappropriate. The work increment (1.21 work RVUs) beyond the base procedure CPT code 43200, *Esophagoscopy, rigid or flexible; with or without collection of specimen(s) by brushing or washing (separate procedure)* is appropriate. Therefore we are maintaining 2.8 work RVUs for CPT code 43219.

CPT code 43256 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)

This code currently has 4.60 work RVUs. We reviewed physician time data for this service and believe that it is overvalued compared to the value of

other stent placement procedures. Therefore, to place it in the proper rank order to other stent placement codes, we are assigning it 4.35 work RVUs. This makes the incremental work (1.96 work RVUs) above the base procedure CPT code 43235, *Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, in line with other stent placement codes.

CPT code 44383 Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)

This code currently has 3.26 work RVUs. We reviewed physician time data for this code and compared it to other stent placement codes. The incremental work value (2.21 work RVUs) above the base procedure CPT code 44380, *Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, is high. Therefore, we are reducing the work RVUs to 2.94. This gives it an incremental work value of 1.89 work RVUs which is similar to the incremental work value of CPT code 44397, *Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)*, and places it in the proper rank order with other stent placement codes.

D. Critical Access Hospital Emergency Services Requirements

Section 1820 of the Act provides for a nationwide Medicare Rural Hospital Flexibility Program (MRHF). The Act also provides that certain rural providers may be designated as critical access hospitals (CAHs) under the MRHF program if they meet qualifying criteria and the conditions for designation specified in the statute. Implementing regulations for section 1820 of the Act are located at 42 CFR part 485, subpart F.

Section 1820(c)(2)(B) of the Act implements specific conditions of participation (CoPs) that a facility must meet to be designated a CAH. The statutory criteria for State designation as a CAH require, in part, that the facility makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a CAH. To help protect the health and safety of Medicare patients who seek emergency medical care at a CAH, our regulations at § 485.618 require CAHs to provide emergency care necessary to meet the needs of its patients.

In 2002, we received letters requesting a special waiver from the current emergency services personnel requirement (specified in § 485.618(d)) for CAHs in frontier areas and remote locations. The requests included the following comments; (1) A number of remote CAHs have been struggling to comply with the current CAH requirement; (2) the personnel requirement places a hardship on isolated frontier communities that have only one medical practitioner; and (3) often these remote facilities have a very low volume of patients which makes it difficult to recover all of their costs and to recruit other practitioners.

As of September 2002, the Cecil G. Sheps Center for Health Services Research at Chapel Hill, North Carolina has identified approximately 173 CAHs that are located in frontier areas (identified as having six individuals per square mile). The average population for a frontier CAH community is 7,024. We have no empirical data to indicate which of these 173 CAHs are currently experiencing workforce issues that create a hardship for the facility or any sole provider. However, the University of Washington conducted a survey of CAHs in May 2001 and learned that, of the 388 CAHs that responded to the survey, 146 facilities are in an isolated small rural census tract. Of these facilities, 10 have no physicians, 24 have only 1 physician, 39 have 2 physicians, and 26 have 3 physicians. Of the CAHs with no doctors, 6 have only 1 mid-level provider (4 of these are in Montana), and 3 have 2 mid-level providers (1 apparently had no physician or mid-level provider at the time of the survey). Of the 39 CAHs that had 2 physicians, 3 had no mid-level providers, and 12 had only 1 mid-level provider.

The Rural Health Research Center at the University of Washington, through its CAH National Tracking Project, reported that CAHs frequently cite problems with recruitment and retention of emergency medical personnel. Based on 2002 data, more than half of the designated CAHs are serving counties dually designated as both a Medically Underserved Area (MUA) and a Health Professional Shortage Area (HPSA). Less than 1 in 10 CAHs are located in counties without a HPSA or an MUA designation.

The delicate balance of providing access to care in very rural and remote areas without jeopardizing quality of care continues to be challenging. We believe that if a small CAH is forced to close because of the lack of qualified personnel, adding RNs to the list of approved personnel would greatly help

CAHs with no greater than 10 beds, in frontier areas or remote locations to serve the emergency health care needs of residents of these areas. Often CAHs in frontier or remote areas are located 50 miles or farther from the nearest health care facility. We believe that allowing RNs, as needed on a temporary basis, to work in CAHs with no greater than 10 beds, with training or experience in emergency care to be included in the list of personnel to be on call and immediately available within 60 minutes is the best means of ensuring that patients in frontier or remote areas will continue to have access to high-quality emergency health care services. However, we are requesting comments on other viable alternatives on how CAHs that are currently experiencing workforce issues can provide emergency care in frontier and remote areas.

Our regulations at § 485.618(d) require a doctor of medicine or osteopathy, a physician's assistant, or a nurse practitioner with training or experience in emergency care to be on call and immediately available by telephone or radio and to be available on site within 30 minutes, or 60 minutes if the CAH is located in a designated frontier area or a remote location designated by the State in its rural health plan. In addition, § 485.618(e) requires that the CAH must coordinate with the emergency response system in the area and ensure the 24-hour telephone or radio availability of a doctor of medicine or osteopathy to receive emergency calls, provide information on treatment of patients, and refer patients to the CAH or other appropriate locations for treatment.

We understand that it may be difficult for small CAHs in frontier areas or remote locations to meet the personnel requirements set forth in § 485.618(d). However, section 1820(c)(2)(B)(ii) of the Act requires a qualifying CAH to make available the 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a CAH. Although the statute does not provide authority to waive the requirement for continuous emergency care services, we believe that the statute provides the flexibility for States to assess their emergency care service needs and permit small CAHs that experience the absence of emergency personnel required by § 485.618(d) to nonetheless provide emergency services. Accordingly, this final rule with comment provides a mechanism for States with CAHs with no greater than 10 beds, in frontier areas and remote locations to include registered nurses (RNs), with training or

experience in emergency care, as authorized emergency services personnel under our current general emergency service personnel requirements at § 485.618(d). Therefore, in this final rule with comment we are revising § 485.618(d) to add the possibility for States to include RNs among authorized personnel, at § 485.618(d)(3). This will permit State Governors, following consultation on the issue of using RNs on a temporary basis as part of their State rural healthcare plan with the State Boards of Medicine and Nursing, and in accordance with State laws, to request in writing the inclusion of RNs to our current personnel requirements, so that RNs may fulfill the emergency personnel requirements of § 485.618 for frontier area or remote location CAHs with no greater than 10 beds. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the State. The letter from the Governor must also describe the circumstances and duration of the temporary request to include the RN on a list of emergency personnel specified in § 485.618(d)(1). The request for such inclusion, and any withdrawal of a request for this inclusion, may be submitted at any time, and will be effective on the date we receive the request. In addition, once a State submits a letter to us signed by the Governor requesting that an RN be included in the list of specified personnel for CAHs with no greater than 10 beds, a CAH must submit documentation to the State survey agency demonstrating that it has not been able, despite reasonable attempts, to hire a sufficient number of physicians, physician assistants, or nurse practitioners to provide 24-hour emergency services on-call coverage. In a frontier or remote area when a CAH has only one physician or mid-level provider, we would expect the facility to provide relief to the sole provider by using an RN with training or experience in emergency services to provide emergency on-call services.

IV. Refinement of Relative Value Units for Calendar Year 2003 and Response to Public Comments on Interim Relative Value Units for 2002

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

Section IV.B of this final rule describes the methodology used to review the comments received on the RVUs for physician work and the

process used to establish RVUs for new and revised CPT codes. Changes to codes on the physician fee schedule reflected in Addendum B are effective for services furnished beginning January 1, 2003.

B. Process for Establishing Work Relative Value Units for the 2003 Physician Fee Schedule

Our November 1, 2001 final rule (66 FR 55294) announced the final work RVUs for Medicare payment for existing procedure codes under the physician fee schedule and interim RVUs for new and revised codes. The RVUs contained in the final rule applied to physician services furnished beginning January 1, 2002. We announced that we considered the RVUs for the interim codes to be subject to public comment under the annual refinement process. In this section, we summarize the refinements to the interim work RVUs published in the November 2001 final rule and our establishment of the work RVUs for new and revised codes for the 2003 physician fee schedule.

Work Relative Value Unit Refinements of Interim and Related Relative Value Units

1. Methodology (Includes Table titled "Work Relative Value Unit Refinements of the 2002 Interim and Related Relative Value Units")

Although the RVUs in the November 2001 final rule were used to calculate 2002 payment amounts, we considered the RVUs for the new or revised codes to be interim. We accepted comments for a period of 60 days. We received substantive comments from many individual physicians and several specialty societies on approximately 19 CPT codes with interim work RVUs. Only comments on codes listed in Addendum C of the November 2001 final rule were considered.

To evaluate these comments we used a process similar to the process used in 1997. (See the October 31, 1997 final rule (62 FR 59084) for the discussion of refinement of CPT codes with interim work RVUs.) We convened a multispecialty panel of physicians to assist us in the review of the comments. The comments that we did not submit to panel review are discussed at the end of this section, as well as those that were reviewed by the panel. We invited representatives from the organization from which we received substantive comments to attend a panel for discussion of the code on which they had commented. The panel was moderated by our medical staff, and consisted of the following voting members:

- One or two clinicians representing the commenting organization.
- Two primary care clinicians nominated by the American Academy of Family Physicians and the American College of Physicians/American Society of Internal Medicine.
- Four carrier medical directors.
- Four clinicians with practices in related specialties, who were expected to have knowledge of the service under review.

The panel discussed the work involved in the procedure under review in comparison to the work associated with other services under the physician fee schedule. We assembled a set of reference services and asked the panel members to compare the clinical aspects of the work of the service a commenter believed was incorrectly valued to one or more of the reference services. In compiling the set, we attempted to include—(1) Services that are commonly performed whose work RVUs are not controversial; (2) services that span the entire spectrum from the easiest to the most difficult; and (3) at least three services performed by each of the major specialties so that each specialty would be represented. The set listed approximately 300 services. Group members were encouraged to make comparisons to reference services. The intent of the panel process was to capture each participant's independent judgement based on the discussion and his or her clinical experience. Following the discussion, each participant rated the work for the procedure. Ratings were individual and confidential, and there was no attempt to achieve consensus among the panel members.

We then analyzed the ratings based on a presumption that the interim RVUs were correct. To overcome this presumption, the inaccuracy of the interim RVUs had to be apparent to the broad range of physicians participating in each panel.

Ratings of work were analyzed for consistency among the groups represented on each panel. In general, we used statistical tests to determine whether there was enough agreement among the groups of the panel and whether the agreed-upon RVUs were significantly different from the interim RVUs published in Addendum C of the November 2001 final rule. We did not modify the RVUs unless there was a clear indication for a change. If there was agreement across groups for change, but the groups did not agree on what the new RVUs should be, we eliminated the outlier group and looked for agreement among the remaining groups as the basis for new RVUs. We used the same methodology in analyzing the ratings

that we first used in the refinement process for the 1993 physician fee schedule. The statistical tests were described in detail in the November 25, 1992 final rule (57 FR 55938).

Our decision to convene multispecialty panels of physicians and to apply the statistical tests described above was based on our need to balance the interests of those who commented on the work RVUs against the redistributive effects that would occur in other specialties.

We also received comments on RVUs that were interim for 2002, but which we did not submit to the panel for review for a variety of reasons. These comments and our decisions on those comments are discussed in further detail below.

The table below lists the interim code reviewed during the refinement process described in this section. This table includes the following information:

- CPT Code. This is the CPT code for a service.

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

- 2002 Work RVU. The work RVUs that appeared in the November 2001 rule are shown for each reviewed code.

- Requested Work RVU. This column identifies the work RVUs requested by commenters.

- 2003 Work RVU. This column contains the final RVUs for physician work.

TABLE 5.—WORK RVU REFINEMENT OF 2002 INTERIM CODES AND RELATED RVUS

CPT code ¹	Description	2002 Work RVU	Requested work RVU	2003 Work RVU
53853	Transurethral destruction of prostate tissue; by water-induced thermotherapy	4.14	8.75	5.24

¹ All CPT codes and descriptions copyright 2003 American Medical Association.

2. Interim 2002 Codes
CPT Code 00797 Anesthesia for Intraoperative Procedures in Upper Abdomen Including Laparoscopy; Gastric Restrictive Procedure for Morbid Obesity CPT Code 01968 Cesarean Delivery Following Neuraxial Labor Analgesia/Anesthesia (List Separately in Addition to Code for Primary Procedure

The RUC recommended that 9 base units be assigned to CPT code 00797 and 3 base units be assigned to the add-on code CPT code 01968. We did not accept the RUC recommended values for these two anesthesia services and assigned 8 base units to CPT code 00797 and 2 base units to the add-on code CPT code 01968.

The AMA and the RUC disagreed with the reductions we made to the base units and the reasoning as stated in the November 1, 2001 final rule behind these reductions. No other comments were received on these codes.

Final Decision: Given that the only comments received were from the AMA and RUC and these provided no additional information, we are maintaining the base units of 8 for CPT code 00797 and 2 base units for the CPT code 01968.

CPT code 47382 Ablation, one or more liver tumor(s), percutaneous, radiofrequency

We had not received recommendations from the RUC for this procedure and assigned work RVUs of 12.00 to this service.

Specialty organizations indicated that the value assigned was inappropriately low and that this would be revisited by the RUC in February 2002. They recommended that we take the RUC values into consideration for the 2003 Medicare fee schedule.

Final Decision: We did receive a RUC recommendation of 15.19 for CPT code 47382 and are in agreement with the recommended work RVU.

CPT code 52001 Cystourethroscopy with irrigation and evacuation of clots.

The RUC recommended 5.45 work RVUs based on a comparison to certain reference procedures. We had concerns about the descriptor associated with this code and based on the descriptor of this CPT code for 2002 assigned 2.37 RVUs to this procedure. We felt the time and intensity of the physician work for this procedure as described was comparable to CPT Code 52005. Commenters acknowledged that the descriptor was being revised and felt that this would enable us to accept the original RUC recommendation of 5.45.

Final decision: The descriptor for CPT code 52001 has been revised for 2003 and the RUC provided a new recommended work RVU of 5.45. We agree with the RUC recommended work RVU of 5.45 for CPT code 52001.

CPT code 53853 Transurethral destruction of prostatic tissue; by water induced thermotherapy).

The RUC recommended 6.41 work RVUs for this procedure. We did not agree with the RUC recommendation and based on an analysis of intraservice activities, we believed it more appropriate to compare CPT code 53853 to 90-day global procedures with less than 30 minutes of intraservice time. Based on this we assigned a work RVU of 4.14 to this code.

Commenters disagreed with the RVUs assigned. One commenter provided detailed information in support of an increase in work RVUs. Based on these comments we referred this code to the

multispecialty validation panel for review.

Final decision: As a result of the statistical analysis of the 2002 multispecialty validation panel ratings, we have assigned 5.24 work RVUs to CPT code 53853.

CPT code 76490 Ultrasound guidance for, and monitoring of, tissue ablation

We did not receive a recommendation from the RUC for this procedure. We compared the time and intensity of this procedure to other radiologic guidance codes and to radiologic supervision and interpretation codes and assigned work RVUs of 2.00 to this code. Two specialty groups expressed concern that the assigned RVUs were not appropriate and indicated the RUC would be revisiting work RVUs for this service in February 2002. They recommended that we take the RUC values into consideration for the 2003 Medicare fee schedule.

Final Decision: We did receive a RUC work RVU recommendation of 4.00 for this service and are in agreement with this recommendation.

CPT code 90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid) and CPT code 90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); each additional vaccine/toxoid (List separately in addition to code for primary procedure) one vaccine

We disagreed with the RUC recommended work RVU of .17 for CPT code 90471 and .15 work RVUs for CPT code 90472. To the extent the physician

performs any counseling related to this service, it is considered part of the work of the preventive medicine visit during which the immunization was administered. If the vaccine is administered during a visit other than a preventive medicine service, any physician counseling should be billed separately as an E/M service. Commenters disagreed that there is no physician work associated with this service particularly in light of the required counseling that must be provided by the physician concerning possible reactions to vaccines. Commenters also continue to be concerned that Medicaid and private payors will base their payment amounts on the "incomplete" RVUs established under the physician fee schedule, which do not include physician work for these services.

Final Decision: We have addressed the issue of immunization administration in a separate section of this rule. We continue to believe that there is no physician work associated with this service. Please see Section A.(3)(c) (Practice Expense provisions for CY 2003) for discussion of this issue.

CPT code 90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid); and, CPT code 90474 Immunization administration by intranasal or oral route each additional vaccine/toxoid (List separately in addition to code for primary procedure)

The RUC recommended a work RVU of .17 for CPT code 90473 and .15 work RVUs for CPT code 90474. Medicare does not cover self-administered vaccines. We did not assign work RVUs to these services as these are noncovered services. Commenters disagreed with our assessment that there is no physician work associated with these codes.

Final Decision: As we had previously indicated, Medicare does not cover self-administered vaccines. Since these services are not covered under Medicare, RVUs are not listed under the physician fee schedule.

CPT code 93609 Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia

We did not receive a recommendation from the RUC for this service. The descriptor for this service did not change, but the AMA CPT editorial panel changed the global period for this service from a zero day global to a ZZZ global. This means that this is now an "add-on" code and the physician work RVUs no longer include any pre- or

postservice work. (It previously had a work RVU of 10.07.) To appropriately value this add-on service, we compared it to several other electrophysiology services and assigned a work RVU of 4.81 to CPT code 93609. Commenters disagreed with the assigned work RVUs and stated that this code would be presented at the February 2002 RUC meeting. Commenters encouraged us to reconsider the work RVUs for this code based on the forthcoming RUC recommendation.

Final Decision: We have received a RUC recommendation of 5.00 for CPT code 93609 for 2003 and are in agreement with this recommendation.

CPT code 93613 Intracardiac electrophysiologic 3-dimensional mapping

This was a new add-on code for 2002 for which we did not receive a recommendation from the RUC. This is a service that does not include any pre- or postservice work. Based on a comparison to similar services, we believed the intraservice time and intensity of 93613 was slightly less than that of CPT code 93619 and therefore assigned 7.00 work RVUs to CPT code 93613. Commenters disagreed with our rationale and stated that this code would be presented at the February 2002 RUC meeting. Commenters encouraged us to reconsider the work RVUs for this code.

Final Decision: We have received a RUC recommendation of 7.00 for CPT code 93613 for 2003 and are in agreement with this recommendation.

CPT code 93701 Bioimpedence, thoracic, electrical

We did not accept the RUC recommendation of 0.00 work RVUs but assigned this service 0.17 work RVUs based on the value assigned to HCPCS code M0302 which is the code used to pay for this service in 2001. We did indicate that we would consider the RUC recommendation but that, if we considered revising the work RVUs, we would discuss any proposed change in a future proposed rule. Commenters expressed concern that we would revisit this issue as we had addressed valuing of this service through rulemaking in 2000. While we retained the work RVUs that had been assigned based on rulemaking in 2000 for this service, we did want to indicate that, in consideration of the RUC recommendation, should we determine that any revisions to the RVUs are necessary, we would address revisions in future rulemaking.

Final Decision: We are retaining the work RVU of 0.17.

CPT code 95250 Glucose monitoring for up to 72 hours by continuous

recording and storage of glucose values from interstitial tissue fluid via a subcutaneous sensor (includes hook-up, calibration, patient initiation and training, recording, disconnection, downloading with printout of data)

We agreed with the RUC recommendation that the physician work value for this service was 0.00. Though the physician can bill an E/M code for the physician review and interpretation associated with this service, commenters believe that use of the E/M code to reflect the physician work is not adequate and that the present reimbursement for this code will discourage its use.

Final Decision: The CPT descriptor for this code indicates that it is for the "TC" only and that, to report the physician review, interpretation and written report associated with this code, the practitioner should use the E/M service codes. Based on this, we believe that the assignment of 0.00 work RVUs is appropriate.

CPT code 97602 Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical applications(s), wound assessment and instruction(s) for ongoing care, per session

The HCPAC recommended a work RVU of 0.32 for this service. We disagreed with this recommendation and stated that the services of this code are bundled into CPT code 97601 and did not establish work RVUs for this service. Commenters disagreed with our determination that this service should be bundled. Commenters felt that, despite the fact that there may be some elements of the service that are common to both codes, these codes describe distinct services that are not used simultaneously. We have re-examined our determination but have not changed our decision. As we explained in last year's final rule, CPT code 97602 describes services that typically involve placement of a wound covering, for example, wet-to-dry gauze or enzyme-treated dressing. It also includes nonspecific removal of devitalized tissue that is an inherent part of changing a dressing. This service is already included in the work and practice expenses of CPT code 97601. In the typical service described by CPT code 97601, the patient has a dressing placed over the wound. We would add that the services described by CPT code 97602 are also included in the work and practice expenses of the whirlpool code, CPT code 97022. For this reason, we consider this a bundled service that is not paid separately.

Final Decision: As discussed above we will continue to consider this a bundled service that is not paid separately.

CPT code 99091 Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time

The RUC recommended work RVUs of 1.10 for this code. We disagreed since this work is considered part of the pre- and post-service work of an E/M service and payment for this code is bundled into payment for the E/M service. Commenters objected to our bundling of this code and believed that the work associated with this service is not captured in other services, as this is not a face-to-face service. Some commenters felt that the work involved in this code was similar to care plan oversight codes, for which we provide separate payment.

Final Decision: Some portion of both the pre- and post-service work of an evaluation and management visit will not be face-to-face. We still conclude, as discussed above, that this a bundled service that is not paid separately.

CPT codes 99289 Physician constant attention of the critically ill or injured patient during an interfacility transport; first 30–74 minutes, and 99290, each additional 30 minutes (List separately in addition to code for primary service)

We did not agree with the RUC recommended values of 4.8 work RVUs for CPT code 99289 and 2.4 work RVUs for CPT code 99290. We also had concerns as to whether the code descriptors for these two new codes, as written, met the requirements for critical care. Based on the concerns outlined in the November 1, 2001 rule, we decided not to recognize these codes for Medicare purposes and created two HCPCS Level II codes for use in CY 2002 to describe critical care services provided to patients during inter-facility transport. These codes (G0240—Critical Care Service delivered by a physician; face-to-face, during inter-facility transport of a critically ill or critically injured patient; first 30–74 minutes of active transport and G0241—each additional 30 minutes (list separately in addition to G0240) were valued at 4.00 work RVUs and 2.00 work RVUs, respectively. Commenters indicated that the descriptors for the CPT codes were being revised and requested that we reconsider the work relative values for these codes in light of the changes that CPT will be making to these codes.

Final Decision: Based on the changes the CPT Editorial Panel has made to the descriptors for CPT codes 99289 and 99290, we are in agreement with the RUC recommended work RVUs of 4.80 for 99289 and 2.40 for 99290 and will use these CPT codes for Medicare purposes. We are also eliminating HCPCS codes G0240 and G0241 that had previously been used to report these services.

RUC Recommendations on Practice Expense Inputs for 2002 New and Revised Codes

In the November 2001 final rule (66 FR 55310), we responded to the RUC recommendations on the practice expense inputs for the new and revised CPT codes for CY 2002. We have received two comments on this issue.

Comment: The AMA commented that it was pleased that we accepted nearly all of the RUC's recommendations for direct practice expense inputs for new and revised codes for CPT 2002.

Response: We are also pleased that we are receiving recommendations on the practice expense inputs that need no modification and thank the RUC for the time and effort expended on developing appropriate recommendations.

Comment: Two organizations representing radiation oncologists were opposed to the reduction of the recommended clinical staff time for a radiation therapist from 123 to 60 minutes for CPT code 77418, intensity modulated treatment delivery. One of the comments argued that there is no overlap of clinical staff time with other services and that the typical time is over 60 minutes for this procedure. Both comments contend that for quality of care purposes two therapists are required.

Response: In the November 2001 final rule (66 FR 55310), we accepted, as interim, the RUC's recommendations for practice expense inputs for CPT code 77418, except that we reduced the staff time from 120 minutes (60 minutes for each of two radiation technologists) to 60 minutes (for one radiation technologist). We still believe that this reduction in staff time is appropriate. IMRT is currently delivered in multiple fractions on a daily basis and is usually administered to patients with prostate cancer or tumors of the head and neck. Most of the treatments take considerably less than 60 minutes and only one technologist is required to actually deliver the treatment, as the parameters are preprogrammed into a computer. Further, any time spent adjusting the radiation fields using ultrasound or computed tomography is separately payable. We believe that 60 minutes of

staff time adequately accounts for the pre-, intra-, and post-service staff resources used to provide this service.

We received the following comments on HCPCS codes established in the November 1, 2001 final rule.

- Respiratory Therapy Codes
 - G0237 Therapeutic Procedures To Increase Strength or Endurance of Respiratory Muscles, Face-to-Face, One-on-One, Each 15 Minutes (Includes Monitoring); G0238 Therapeutic Procedures To Improve Respiratory Function, Other Than Described by G0237, One-on-One, Face-to-Face, per 15 Minutes (Includes Monitoring); and G0239 Therapeutic Procedures To Improve Respiratory Function, Two or More Patients Treated During the Same Period, Face-to-Face (Includes Monitoring).*

Note that we have revised the descriptor for G0239 for clarity, and discussed this in section IV(C).

While several organizations expressed appreciation for the establishment of these codes, they requested clarification on the following points:

Comment: Commenters asked whether nurses could also use these codes.

Response: Physicians can use these codes if nurses are providing services "incident to" a physician's service, with the physician in the suite in his or her office, and the codes may be used in a comprehensive outpatient rehabilitation facility (CORF) or a hospital outpatient department. Since there is no respiratory therapy or pulmonary rehabilitation benefit, respiratory therapists can provide these services only in a CORF or under the "incident to" provision in a physician's office or in the hospital outpatient setting.

Comment: Commenters requested clarification of the term "monitoring" used in all three of these code descriptions.

Response: Monitoring provides physiologic or other data about the patient during the period before, during, and after the activities. It can represent, for example, pulse oximetry readings, electrocardiography data, pulmonary testing measurements, or measurements of strength or endurance performed to assess the status of the patient before, during, and after the activities. An example would be pursed-lip breathing which involves nasal inspiration followed by slow exhalations through partially closed pursed lips to create positive pressure in upper respiratory tract, and improve respiratory muscles action. If, after this training, the practitioner were to check the patient's oxygen saturation level (via pulse oximetry), peak respiratory flow, or

other respiratory parameters, then this would be considered "monitoring." Payment for this monitoring is bundled into G0237 and not paid separately as a diagnostic test.

Comment: Another asked about the differences between the G codes.

Response: G0237 involves therapeutic procedures specifically targeted at improving the strength and endurance of respiratory muscles. Examples include pursed-lip breathing, diaphragmatic breathing, and paced breathing (strengthening the diaphragm by breathing through tubes of progressively increasing resistance to flow). G0238 involves a variety of activities including teaching patients strategies for performing tasks with less respiratory effort and the performance of graded activity programs to increase endurance and strength of upper and lower extremities. G0238 does not include demonstration of the use of nebulizer or inhaler or chest percussions because these services are described by other CPT codes (94664 and 94667, respectively). G0239 represents situations in which two or more patients are receiving services simultaneously (such as those described above in G0237 or G0238) during the same time period. The practitioners must be in constant attendance but need not be providing one-on-one contact. For example, a therapist provides medically necessary therapeutic procedures to two patients (A and B) in the same gym, for a 30-minute period. Both are performing different graded activities (described by G0238) to increase endurance of their upper and lower extremities while the therapist divides his/her time—in intermittent, brief episodes—between patients A and B. In this scenario the therapist would bill each patient for group therapy (G0239) because the treatment was provided simultaneously to two patients, and not one-on-one, as required by G0238.

Comment: Commers requested clarification concerning use of G0237, G0238, and G0239 codes and whether these codes can be billed more than once a day.

Response: G0237 and G0238 are timed codes, reported for each 15 minutes of one-on-one face-to-face treatment. They can be reported with more than one unit per patient per day, depending upon the duration of treatment. G0239 is not a timed code and thus should be reported only once a day for each patient in the group.

Comment: Clarification was also requested about whether the physician must certify the services every 30 days.

Response: The 30-day certification and recertification of the plan of care requirement applies to the services of physical therapists, occupational therapists, and speech language pathologists as described in section 1861(p) of the Act. Since we expected G0237, G0238, and G0239 typically to be provided by respiratory therapists, the 30-day certification and recertification of the plan of care requirement does not generally apply. If the services are performed by either a physical or occupational therapist (or by a therapy assistant under his or her direction), the requirement for the 30-day certification and recertification applies. Additionally, all services provided in the CORF setting including G0237, G0238, and G0239 require 60-day certification and recertification of the plan of care.

Comment: One commenter asked whether the "NA" in the facility total column indicated that these codes are not for use in the hospital outpatient setting.

Response: As stated above, these codes are appropriate for use in the hospital outpatient setting. The "NA" refers to the fact that in the hospital outpatient setting, these codes are paid under the hospital outpatient prospective payment system and are assigned to an APC, rather than being paid on the physician fee schedule.

Comment: Commenters also asked for the specific clinical situations in which the use of these codes is appropriate.

Response: All services must meet the test of being "reasonable and necessary" pursuant to section 1862(a)(1)(A) of the Act. Determinations of medical necessity have been made by carriers and intermediaries on a claim-by-claim basis in their local medical review policies. We believe that this is the appropriate manner to address these questions, and many of our contractors have already developed these policies. We note however, there is no explicit pulmonary rehabilitation benefit.

Comment: Commenters asked whether respiratory therapists would be precluded from using additional CPT codes to bill for their pulmonary-rehabilitation related services.

Response: We reiterate that codes G0237, G0238, and G0239 were developed to provide more specificity about the services being delivered. Thus, CPT codes 97000 to 97799 are not to be billed by professionals involved in treating respiratory conditions, unless these services are delivered by physical or occupational therapists and meet the other requirements for physical and occupational therapy services. Also CPT code 99211, (office or other outpatient

visit for evaluation and management), should not be used by practitioners providing outpatient respiratory or pulmonary therapy services.

Revisions to Malpractice RVUs for New and Revised CPT Codes for 2002

Malpractice RVUs are calculated using the methodology described in detail at Addendum G of our November 1, 2000 final rule (65 FR 65589). Because of the timing of the release of new and revised CPT codes each year, the malpractice RVUs for the first year of these codes are extrapolated from existing similar codes based on the advice of our medical consultants and are considered interim subject to public comment and our revision. The following year, these codes are given values based on our malpractice RVU methodology and a review of any comments received.

The malpractice RVUs for new and revised codes for CY 2002 published in Addendum B of the November 2001 final rule, were extrapolated from existing similar codes. The malpractice RVUs for these codes in this year's Addendum B were calculated by our consultant, KPMG, using the same methodology used for all other codes. Likewise, the malpractice RVUs for new and revised codes for CY 2003 are being extrapolated from existing similar codes and will be calculated using the malpractice RVU methodology next year.

Comment: The American College of Radiology continues to be concerned about the increasing liability costs for radiology and radiation oncology. They would like us to explore and ultimately implement a change in the malpractice methodology. They stated that radiologists and radiation oncologists bear the majority of costs for liability insurance; therefore, the larger proportion of malpractice value should be included in the PC and the smaller portion in the TC.

Response: While we can understand the concern about rising liability costs, we do not believe that radiology and radiation oncology are the only specialties facing such increases. We also do not agree that the larger proportion of malpractice values should be associated with the PC component of the service. As we have explained in previous physician fee schedule rules, the total TC RVUs (practice expense and malpractice) for the TC of radiology diagnostic tests represent the expenses required to perform the test—equipment, supplies, and technicians plus malpractice insurance. The total PC RVUs (work, practice expense and malpractice insurance) represent only

the interpretation of the test by the physician. Generally, the TC RVUs for radiology services are significantly higher than the PC RVUs because of the very expensive equipment and supplies. The malpractice RVUs are generally split in similar proportion between PC and TC as are the practice expense RVUs. In cases when the physician or group provides both the TC and PC and bills for both components, the split is not a significant issue since the physician or group would receive the total payment. In many cases, the TC is provided by an entity—hospital or free standing imaging center—other than the physician providing the interpretation. The entity providing the TC, which includes a supervising physician who is most likely a radiologist, assumes the risk, such as excessive irradiation of the patient, of providing the TC. We can think of no reason to transfer any portion of malpractice RVUs from the entity (which would include a supervising physician) providing the majority of the service, the TC, to a physician who is providing only the interpretation. The malpractice liability associated with interpreting the test is reflected in the PC malpractice RVUs.

Comment: The American Occupational Therapy Association indicated that for computing malpractice RVUs, occupational therapy was incorrectly crosswalked to occupational medicine (Insurance Service Office (ISO) code 80233). They suggested the appropriate crosswalk is to physical medicine and rehabilitation (ISO 80235).

Response: We agree with the commenter that a more appropriate crosswalk for occupational therapy is to physical medicine and rehabilitation as opposed to occupational medicine. The original data that were used to calculate malpractice RVUs were based upon 1993 to 1995 malpractice premium data. These data were replaced with more recent premium data (1996 to 1998). The resulting risk factors are published in the November 2000 final rule (65 FR 65594). These more recent premium data place occupation medicine, occupational therapy, and physical medicine and rehabilitation into the same risk classification. Due to this update to the risk classifications, revising the crosswalk for occupational therapy will have no effect; nonetheless, for purposes of accuracy, we will change the occupational therapy

crosswalk at the next scheduled update to malpractice premium data in CY 2005.

Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2003 (Includes Table titled American Medical Association Specialty Relative Value Update Committee and Health Care Professionals Advisory Committee Recommendations and CMS's Decisions for New and Revised 2003 CPT Codes)

One aspect of establishing RVUs for 2003 was related to the assignment of interim work RVUs for all new and revised CPT codes. As described in our November 25, 1992 notice on the 1993 physician fee schedule (57 FR 55983) and in section III.B. of the November 22, 1996 final rule (61 FR 59505 through 59506), we established a process, based on recommendations received from the AMA's RUC, for establishing interim work RVUs for new and revised codes.

This year we received work RVU recommendations for approximately 249 new and revised CPT codes from the RUC. Our staff and medical officers reviewed the RUC recommendations by comparing them to our reference set or to other comparable services for which work RVUs had previously been established, or to both of these criteria. We also considered the relationships among the new and revised codes for which we received RUC recommendations. We agreed with the majority of the relative relationships reflected in the RUC values. In some instances, when we agreed with the relationships, we nonetheless revised the work RVUs to achieve work neutrality within families of codes, that is, the work RVUs have been adjusted so that the sum of the new or revised work RVUs (weighted by projected frequency of use) for a family will be the same as the sum of the current work RVUs (weighted by projected frequency of use). For approximately 96 percent of the RUC recommendations, proposed work RVUs were reviewed and accepted, and, for approximately 4 percent, we disagreed with the RUC recommended values. In the majority of these instances, we agreed with the relativity established by the RUC, but needed to adjust work RVUs to retain budget neutrality.

There were also 22 CPT codes for which we did not receive a RUC recommendation. After a review of these CPT codes by our staff and medical officers, we established interim work RVUs for the majority of these services. For those services for which we could not arrive at interim work RVUs, we have assigned a carrier-priced status until such time as the RUC provides work RVU recommendations.

We received 22 recommendations from the Health Care Professionals Advisory Committee (HCPAC). We agreed with approximately 86 percent of the HCPAC recommendations and disagreed with approximately 14 percent of the HCPAC recommendations.

We have also included, in Table 6, 34 codes for which the RUC has submitted revisions to their original 2002 recommendations. These CPT codes are identified with an "L" in Table 6.

Table 6, titled "AMA RUC and HCPAC Recommendations and CMS Decisions for New and Revised 2003 CPT Codes", lists the new or revised CPT codes, and their associated work RVUs, that will be interim in 2003. This table includes the following information:

- A "#" identifies a new code for 2003.
- CPT code. This is the CPT code for a service.
- Modifier. A "26" in this column indicates that the work RVUs are for the professional component of the code.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC recommendations. This column identifies the work RVUs recommended by the RUC.
- HCPAC recommendations. This column identifies the work RVUs recommended by the HCPAC.
- CMS decision. This column indicates whether we agreed with the RUC recommendation ("agree") or we disagreed with the RUC recommendation ("disagree"). Codes for which we did not accept the RUC recommendation are discussed in greater detail following this table. An "(a)" indicates that no RUC recommendation was provided.
- 2003 Work RVUs. This column establishes the 2003 work RVUs for physician work.

TABLE 6

*CPT code	Mod	Description	RUC rec-ommendation	HCPAC rec-ommendation	CMS decision	2003 Work RVU
11400	Exc tr-ext b9+marg 0.5 < cm	0.85	.....	Agree	0.85
11401	Exc tr-ext b9+marg 0.6-1 cm	1.23	.....	Agree	1.23
11402	Exc tr-ext b9+marg 1.1-2 cm	1.51	.....	Agree	1.51
11403	Exc tr-ext b9+marg 2.1-3 cm	1.79	.....	Agree	1.79
11404	Exc tr-ext b9+marg 3.1-4cm	2.06	.....	Agree	2.06
11406	Exc tr-ext b9+marg > 4.0 cm	2.76	.....	Agree	2.76
11420	Exc h-f-nk-sp b9+marg 0.5 <	0.98	.....	Agree	0.98
11421	Exc h-f-nk-sp b9+marg 0.6-1	1.42	.....	Agree	1.42
11422	Exc h-f-nk-sp b9+marg 1.1-2	1.63	.....	Agree	1.63
11423	Exc h-f-nk-sp b9+marg 2.1-3	2.01	.....	Agree	2.01
11424	Exc h-f-nk-sp b9+marg 3.1-4	2.43	.....	Agree	2.43
11426	Exc h-f-nk-sp b9+marg > 4 cm	3.78	.....	Agree	3.78
11440	Exc face-mm b9+marg 0.5 < cm	1.06	.....	Agree	1.06
11441	Exc face-mm b9+marg 0.6-1 cm	1.48	.....	Agree	1.48
11442	Exc face-mm b9+marg 1.1-2 cm	1.72	.....	Agree	1.72
11443	Exc face-mm b9+marg 2.1-3 cm	2.29	.....	Agree	2.29
11444	Exc face-mm b9+marg 3.1-4 cm	3.14	.....	Agree	3.14
11446	Exc face-mm b9+marg > 4 cm	4.49	.....	Agree	4.49
11600	Exc tr-ext mlg+marg 0.5 < cm	1.31	.....	Agree	1.31
11601	Exc tr-ext mlg+marg 0.6-1 cm	1.80	.....	Agree	1.80
11602	Exc tr-ext mlg+marg 1.1-2 cm	1.95	.....	Agree	1.95
11603	Exc tr-ext mlg+marg 2.1-3 cm	2.19	.....	Agree	2.19
11604	Exc tr-ext mlg+marg 3.1-4 cm	2.40	.....	Agree	2.40
11606	Exc tr-ext mlg+marg > 4 cm	3.43	.....	Agree	3.43
11620	Exc h-f-nk-sp mlg+marg 0.5 <	1.19	.....	Agree	1.19
11621	Exc h-f-nk-sp mlg+marg 0.6-1	1.76	.....	Agree	1.76
11622	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	.....	Agree	2.09
11623	Exc h-f-nk-sp mlg+marg 2.1-3	2.61	.....	Agree	2.61
11624	Exc h-f-nk-sp mlg+marg 3.1-4	3.06	.....	Agree	3.06
11626	Exc h-f-nk-sp mlg+mar > 4 cm	4.30	.....	Agree	4.30
11640	Exc face-mm malig+marg 0.5 <	1.35	.....	Agree	1.35
11641	Exc face-mm malig+marg 0.6-1	2.16	.....	Agree	2.16
11642	Exc face-mm malig+marg 1.1-2	2.59	.....	Agree	2.59
11643	Exc face-mm malig+marg 2.1-3	3.10	.....	Agree	3.10
11644	Exc face-mm malig+marg 3.1-4	4.03	.....	Agree	4.03
11646	Exc face-mm mlg+marg > 4 cm	5.95	.....	Agree	5.95
L 11981	Insert drug implant device	1.48	.....	Agree	1.48
L 11982	Remove drug implant device	1.78	.....	Agree	1.78
L 11983	Remove/insert drug implant	3.30	.....	Agree	3.30
17304	1 stage mohs, up to 5 spec	7.60	.....	Agree	7.60
17305	2 stage mohs, up to 5 spec	2.85	.....	Agree	2.85
17306	3 stage mohs, up to 5 spec	2.85	.....	Agree	2.85
17307	Mohs addl stage up to 5 spec	2.85	.....	Agree	2.85
17310	Mohs any stage > 5 spec each	0.95	.....	Disagree	0.62
L 20526	Ther injection, carp tunnel	0.94	.....	Agree	0.94
L 20550	Inj tendon sheath/ligament	0.75	.....	Agree	0.75
L 20551	Inject tendon origin/insert	0.75	.....	Agree	0.75
L 20552	Inject trigger point, 1 or 2	0.66	.....	Agree	0.66
L 20553	Inject trigger points, => 3	0.75	.....	Agree	0.75
L 20600	Drain/inject, joint/bursa	0.66	.....	Agree	0.66
L 20605	Drain/inject, joint/bursa	0.68	.....	Agree	0.68
# 20612	Aspirate/inj ganglion cyst	0.70	.....	Agree	0.70
21030	Excise max/zygoma b9 tumor	(a)	.....	(a)	3.89
21034	Excise max/zygoma mlg tumor	16.17	.....	Agree	16.17
21040	Removal of jaw bone lesion	(a)	.....	(a)	3.89
# 21046	Remove mandible cyst complex	13.00	.....	Agree	13.00
# 21047	Excise lwr jaw cyst w/repair	18.75	.....	Agree	18.75
# 21048	Remove maxilla cyst complex	13.50	.....	Agree	13.50
# 21049	Excise uppr jaw cyst w/repair	18.00	.....	Agree	18.00
21740	Reconstruction of sternum	16.50	.....	Agree	16.50
# 21742	Repair sternum/nuss w/o scope	(a)	.....	(a)	carrier
# 21743	Repair sternum/nuss w/scope	(a)	.....	(a)	carrier
23410	Repair rotator cuff, acute	12.45	.....	Agree	12.45
23412	Repair rotator cuff, chronic	13.31	.....	Agree	13.31
L 24344	Reconstruct elbow lat ligmnt	14.00	.....	Agree	14.00
L 24346	Reconstruct elbow med ligmnt	14.00	.....	Agree	14.00
25320	Repair/revise wrist joint	10.77	.....	Agree	10.77
27425	Lat retinacular release open	5.22	.....	Agree	5.22
27730	Repair of tibia epiphysis	7.41	.....	Agree	7.41
27732	Repair of fibula epiphysis	5.32	.....	Agree	5.32
27734	Repair of lower leg epiphysis	8.48	.....	Agree	8.48

TABLE 6—Continued

*CPT code	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2003 Work RVU
27870	Fusion of ankle joint, open	13.91	.....	Agree	13.91
29806	Shoulder arthroscopy/surgery	14.37	.....	Agree	14.37
# 29827	Arthroscop rotator cuff repr	15.36	.....	Agree	15.36
# 29873	Knee arthroscopy/surgery	6.00	.....	Agree	6.00
# 29899	Ankle arthroscopy/surgery	13.91	.....	Agree	13.91
# 33215	Reposition pacing-defib lead	4.44	.....	Disagree	4.76
33216	Insert lead pace-defib, one	5.39	.....	Disagree	5.78
33217	Insert lead pace-defib, dual	5.75	.....	Agree	5.75
# 33224	Insert pacing lead & connect	9.05	.....	Agree	9.05
# 33225	L ventric pacing lead add-on	8.34	.....	Agree	8.34
# 33226	Reposition L ventric lead	8.69	.....	Agree	8.69
# 33508	Endoscopic vein harvest	0.31	.....	Agree	0.31
L 33979	Insert intracorporeal device	46.00	.....	Agree	46.00
L 33980	Remove intracorporeal device	56.25	.....	Agree	56.25
34812	Xpose for endoprosth, femorl	6.75	.....	Agree	6.75
34825	Endovasc extend prosth, init	12.00	.....	Agree	12.00
34826	Endovasc extend prosth, addl	4.13	.....	Agree	4.13
# 34833	Xpose for endoprosth, iliac	12.00	.....	Agree	12.00
# 34834	Xpose, endoprosth, brachial	5.35	.....	Agree	5.35
# 34900	Endovasc iliac repr w/graft	16.38	.....	Agree	16.38
# 35572	Harvest femoropopliteal vein	6.82	.....	Agree	6.82
36415	Routine venipuncture	0.00	.....	Agree	0.00
# 36416	Capillary blood draw	0.00	.....	Agree	0.00
# 36511	Apheresis wbc	(a)	.....	(a)	1.74
# 36512	Apheresis rbc	(a)	.....	(a)	1.74
# 36513	Apheresis platelets	(a)	.....	(a)	1.74
# 36514	Apheresis plasma	(a)	.....	(a)	1.74
# 36515	Apheresis, adsorp/reinfuse	(a)	.....	(a)	1.74
# 36516	Apheresis, selective	(a)	.....	(a)	1.74
# 36536	Remove cva device obstruct	3.60	.....	Agree	3.60
# 36537	Remove cva lumen obstruct	0.75	.....	Agree	0.75
36540	Collect blood venous device	0.00	.....	Agree	0.00
# 37182	Insert hepatic shunt (tips)	17.00	.....	Agree	17.00
# 37183	Remove hepatic shunt (tips)	8.00	.....	Agree	8.00
# 37500	Endoscopy ligate perf veins	11.00	.....	Agree	11.00
37760	Ligation, leg veins, open	10.47	.....	Agree	10.47
# 38204	BI donor search management	2.00	.....	Disagree	0.00
# 38205	Harvest allogenic stem cells	1.50	.....	Agree	1.50
# 38206	Harvest auto stem cells	1.50	.....	Agree	1.50
# 38207	Cryopreserve stem cells	(a)	.....	(a)	0.00
# 38208	Thaw preserved stem cells	(a)	.....	(a)	0.00
# 38209	Wash harvest stem cells	(a)	.....	(a)	0.00
# 38210	T-cell depletion of harvest	(a)	.....	(a)	0.00
# 38211	Tumor cell deplete of harvest	(a)	.....	(a)	0.00
# 38212	Rbc depletion of harvest	(a)	.....	(a)	0.00
# 38213	Platelet deplete of harvest	(a)	.....	(a)	0.00
# 38214	Volume deplete of harvest	(a)	.....	(a)	0.00
# 38215	Harvest stem cell concentrtr	(a)	.....	(a)	0.00
# 38242	Lymphocyte infuse transplant	1.71	.....	Agree	1.71
# 43201	Esoph scope w/submucous inj	2.09	.....	Agree	2.09
# 43236	Uppr gi scope w/submuc inj	2.92	.....	Agree	2.92
43245	Uppr gi scope dilate strictr	3.18	.....	Agree	3.18
# 44206	Lap part colectomy w/stoma	27.00	.....	Agree	27.00
# 44207	L colectomy/coloproctostomy	30.00	.....	Agree	30.00
# 44208	L colectomy/coloproctostomy	32.00	.....	Agree	32.00
# 44210	Laparo total proctocolectomy	28.00	.....	Agree	28.00
# 44211	Laparo total proctocolectomy	35.00	.....	Agree	35.00
# 44212	Laparo total proctocolectomy	32.50	.....	Agree	32.50
# 44701	Intraop colon lavage add-on	3.10	.....	Agree	3.10
# 45335	Sigmoidoscope w/submuc inj	1.46	.....	Disagree	1.36
# 45340	Sig w/balloon dilation	1.96	.....	Disagree	1.66
# 45381	Colonoscope, submucous inj	4.30	.....	Disagree	4.20
# 45386	Colonoscope dilate stricture	4.58	.....	Agree	4.58
# 46706	Repr of anal fistula w/glue	2.95	.....	Disagree	2.39
L 47370	Laparo ablate liver tumor rf	19.69	.....	Agree	19.69
L 47371	Laparo ablate liver cryosurg	19.69	.....	Agree	19.69
L 47380	Open ablate liver tumor rf	23.00	.....	Agree	23.00
L 47381	Open ablate liver tumor cryo	23.27	.....	Agree	23.27
L 47382	Percut ablate liver rf	15.19	.....	Agree	15.19
# 49419	Insrt abdom cath for chemotx	6.65	.....	Agree	6.65
# 49904	Omental flap, extra-abdom	20.00	.....	Agree	20.00

TABLE 6—Continued

*CPT code	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2003 Work RVU
49905	Omental flap, intra-abdom	6.55	.....	Agree	6.55
# 50542	Laparo ablate renal mass	20.00	.....	Agree	20.00
# 50543	Laparo partial nephrectomy	25.50	.....	Agree	25.50
# 50562	Renal scope w/tumor resect	10.90	.....	Agree	10.90
# 55866	Laparo radical prostatectomy	30.74	.....	Agree	30.74
# 51701	Insert bladder catheter	0.50	.....	Agree	0.50
# 51702	Insert temp bladder cath	0.50	.....	Agree	0.50
# 51703	Insert bladder cath, complex	1.47	.....	Agree	1.47
# 51798	Us urine capacity measure	0.38	.....	Disagree	0.11
53440	Male sling procedure	13.62	.....	Agree	13.62
53442	Remove/revise male sling	11.57	.....	Agree	11.57
# 56820	Exam of vulva w/scope	1.50	.....	Agree	1.50
# 56821	Exam/biopsy of vulva w/scope	2.05	.....	Agree	2.05
# 57420	Exam of vagina w/scope	1.60	.....	Agree	1.60
# 57421	Exam/biopsy of vag w/scope	2.20	.....	Agree	2.20
# 57452	Exam of cervix w/scope	1.50	.....	Agree	1.50
# 57454	Bx/curett of cervix w/scope	2.33	.....	Agree	2.33
# 57455	Biopsy of cervix w/scope	1.99	.....	Agree	1.99
# 57456	Endocerv curettage w/scope	1.85	.....	Agree	1.85
# 57460	Bx of cervix w/scope, leep	2.83	.....	Agree	2.83
# 57461	Conz of cervix w/scope, leep	3.44	.....	Agree	3.44
58140	Myomectomy abdom method	14.60	.....	Agree	14.60
58145	Myomectomy vag method	8.04	.....	Agree	8.04
# 58146	Myomectomy abdom complex	19.00	.....	Agree	19.00
58260	Vaginal hysterectomy	12.98	.....	Agree	12.98
58262	Vag hyst including t/o	14.77	.....	Agree	14.77
58263	Vag hyst w/t/o & vag repair	16.06	.....	Agree	16.06
58267	Vag hyst w/urinary repair	17.04	.....	Agree	17.04
58270	Vag hyst w/enterocele repair	14.26	.....	Agree	14.26
# 58290	Vag hyst complex	19.00	.....	Agree	19.00
# 58291	Vag hyst incl t/o, complex	20.79	.....	Agree	20.79
# 58292	Vag hyst t/o & repair, compl	22.08	.....	Agree	22.08
# 58293	Vag hyst w/uro repair, compl	23.06	.....	Agree	23.06
# 58294	Vag hyst w/enterocele, compl	20.28	.....	Agree	20.28
# 58545	Laparoscopic myomectomy	14.60	.....	Agree	14.60
# 58546	Laparo-myomectomy, complex	19.00	.....	Agree	19.00
58550	Laparo-assst vag hysterectomy	14.19	.....	Agree	14.19
# 58552	Laparo-vag hyst incl t/o	14.19	.....	Agree	14.19
# 58553	Laparo-vag hyst, complex	19.00	.....	Agree	19.00
# 58554	Laparo-vag hyst w/t/o, compl	19.00	.....	Agree	19.00
# 61316	Implt cran bone flap to abdo	1.39	.....	Agree	1.39
# 61322	Decompressive craniotomy	29.50	.....	Agree	29.50
# 61323	Decompressive lobectomy	31.00	.....	Agree	31.00
61340	Subtemporal decompression	18.66	.....	Agree	18.66
# 61517	Implt brain chemotx add-on	1.38	.....	Agree	1.38
# 61623	Endovasc tempory vessel occl	9.96	.....	Agree	9.96
61624	Transcath occlusion, cns	20.15	.....	Agree	20.15
# 62148	Retr bone flap to fix skull	2.00	.....	Agree	2.00
# 62160	Neuroendoscopy add-on	3.00	.....	Agree	3.00
# 62161	Dissect brain w/scope	20.00	.....	Agree	20.00
# 62162	Remove colloid cyst w/scope	25.25	.....	Agree	25.25
# 62163	Neuroendoscopy w/fb removal	15.50	.....	Agree	15.50
# 62164	Remove brain tumor w/scope	27.50	.....	Agree	27.50
# 62165	Remove pituit tumor w/scope	22.00	.....	Agree	22.00
62201	Brain cavity shunt w/scope	14.86	.....	Agree	14.86
62263	Epidural lysis mult sessions	6.14	.....	Agree	6.14
# 62264	Epidural lysis on single day	4.43	.....	Agree	4.43
64415	N block inj, brachial plexus	1.48	.....	Agree	1.48
# 64416	N block cont infuse, b plex	3.50	.....	Agree	3.50
64445	N block inj, sciatic, sng	1.48	.....	Agree	1.48
# 64446	N blk inj, sciatic, cont inf	3.25	.....	Agree	3.25
# 64447	N block inj fem, single	1.50	.....	Agree	1.50
# 64448	N block inj fem, cont inf	3.00	.....	Agree	3.00
64450	N block, other peripheral	1.27	.....	Agree	1.27
# 66990	Ophthalmic endoscope add-on	1.51	.....	Agree	1.51
# 75901	26	Remove cva device obstruct	0.49	.....	Agree	0.49
# 75902	26	Remove cva lumen obstruct	0.39	.....	Agree	0.39
75953	26	Abdom aneurysm endovas rpr	1.36	.....	Agree	1.36
# 75954	26	Iliac aneurysm endovas rpr	2.93	.....	Disagree	1.36
76070	26	Ct bone density, axial	0.25	.....	Agree	0.25
# 76071	26	Ct bone density, peripheral	0.22	.....	Agree	0.22

TABLE 6—Continued

*CPT code	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2003 Work RVU
L 76085	26 ...	Computer mammogram add-on	0.06	.....	Agree	0.06
L 76362E	26 ...	CAT scan for tissue ablation	4.00	.....	Agree	4.00
L 76394	26 ...	MRI for tissue ablation	4.25	.....	Agree	4.25
L 76490	26 ...	US for tissue ablation	4.00	.....	Agree	4.00
# 76801	Ob us < 14 wks, single fetus	0.99	.....	Agree	0.99
# 76802	Ob us < 14 wks, addl fetus	0.83	.....	Agree	0.83
76805	Ob us ≥ 14 wks, snl fetus	0.99	.....	Agree	0.99
76810	Ob us ≥ 14 wks, addl fetus	0.98	.....	Agree	0.98
# 76811	Ob us, detailed, snl fetus	1.90	.....	Agree	1.90
# 76812	Ob us, detailed, addl fetus	1.78	.....	Agree	1.78
76815	Ob us, limited, fetus(s)	0.65	.....	Agree	0.65
76816	Ob us, follow-up, per fetus	0.85	.....	Agree	0.85
# 76817	Transvaginal us, obstetric	0.75	.....	Agree	0.75
# 92601	Cochlear implt f/up exam < 7 .....	.....	0.00	Agree	0.00
# 92602	Reprogram cochlear implt < 7 .....	.....	0.00	Agree	0.00
# 92603	Cochlear implt f/up exam 7 > .....	.....	0.00	Agree	0.00
# 92604	Reprogram cochlear implt 7 > .....	.....	0.00	Agree	0.00
# 92605	Eval for nonspeech device rx .....	.....	0.00	Agree	0.00
# 92606	Non-speech device service .....	.....	0.00	Agree	0.00
# 92607	Ex for speech device rx, 1hr .....	.....	0.00	Agree	0.00
# 92608	Ex for speech device rx addl .....	.....	0.00	Agree	0.00
# 92609	Use of speech device service .....	.....	0.00	Agree	0.00
# 92610	Evaluate swallowing function .....	.....	0.00	Agree	0.00
# 92611	Motion fluoroscopy/swallow .....	.....	0.00	Agree	0.00
# 92612	Endoscopy swallow tst (fees) .....	.....	1.27	Agree	1.27
# 92613	Endoscopy swallow tst (fees) .....	.....	0.99	Disagree	0.00
# 92614	Laryngoscopic sensory test .....	.....	1.27	Agree	1.27
# 92615	Eval laryngoscopy sense tst .....	.....	0.88	Disagree	0.00
# 92616	Fees w/laryngeal sense test .....	.....	1.88	Agree	1.88
# 92617	Interprt fees/laryngeal test .....	.....	1.10	Disagree	0.00
# 93580	Transcath closure of asd	18.00	.....	Agree	18.00
# 93581	Transcath closure of vsd	24.43	.....	Agree	24.43
L 93609	26 ...	Map tachycardia, add-on	5.00	.....	Agree	5.00
L 93613	Electrophys map 3d, add-on	7.00	.....	Agree	7.00
L 93619	26 ...	Electrophysiology evaluation	7.32	.....	Agree	7.32
L 93620	26 ...	Electrophysiology evaluation	11.59	.....	Agree	11.59
L 93621	26 ...	Electrophysiology evaluation	2.10	.....	Agree	2.10
L 93622	26 ...	Electrophysiology evaluation	3.10	.....	Agree	3.10
# 95990	Spin/brain pump refill & main	(a)	.....	(a)	0.00
L 96000	Motion analysis, video/3d .....	.....	1.80	Agree	1.80
L 96001	Motion test w/ft press meas .....	.....	2.15	Agree	2.15
L 96002	Dynamic surface emg .....	.....	0.41	Agree	0.41
L 96003	Dynamic fine wire emg .....	.....	0.37	Agree	0.37
L 96004	Phys review of motion tests .....	.....	2.14	Agree	2.14
96530	Syst pump refill & main	0.00	.....	Agree	0.00
# 96920	Laser tx, skin < 250 sq cm	1.15	.....	Agree	1.15
# 96921	Laser tx, skin 250–500 sq cm	1.17	.....	Agree	1.17
# 96922	Laser tx, skin > 500 sq cm	2.10	.....	Agree	2.10
# 99026	In-hospital on call service	(a)	.....	(a)	0.00
# 99027	Out-of-hosp on call service	(a)	.....	(a)	0.00
99289	Ped crit care transport	4.80	.....	Agree	4.80
99290	Ped crit care transport addl	2.40	.....	Agree	2.40
# 99293	Ped critical care, initial	16.00	.....	Agree	16.00
# 99294	Ped critical care, subseq	8.00	.....	Agree	8.00
99295	Neonate crit care, initial	18.49	.....	Agree	18.49
99296	Neonate critical care subseq	8.00	.....	Agree	8.00
99298	Neonatal critical care	2.75	.....	Agree	2.75
# 99299	lc, lbw infant 1500–2500 gm	2.50	.....	Agree	2.50

(a) No Final RUC recommendation provided.

New CPT codes.

*All CPT codes copyright 2002 American Medical Association.

L Revised 2002 RUC recommendations.

Table 7, which is titled “AMA RUC ANESTHESIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2003 CPT CODES”, lists the new or revised CPT codes for anesthesia

and their base units that will be interim in 2003. This table includes the following information:

- CPT code. This is the CPT code for a service.

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

- RUC recommendations. This column identifies the base units recommended by the RUC.
- CMS decision. This column indicates whether we agreed with the

RUC recommendation (“agree”) or we disagreed with the RUC recommendation (“disagree”). Codes for which we did not accept the RUC

recommendation are discussed in greater detail following this table.

- 2003 Base Units. This column establishes the 2003 base units for these services.

TABLE 7

*CPT code	Description	RUC recommendation	CMS decision	2003 base units
#00326	Anesth, larynx/trach, < 1 yr	7	Agree	7
#00539	Anesth, trach-bronch reconst	18	Agree	18
#00540	Anesth, chest surgery	12	Agree	12
#00541	Anesth, one lung ventilation	15	Agree	15
#00640	Anesth, spine manipulation	3	Agree	3
#00834	Anesth, hernia repair < 1 yr	5	Agree	5
#00836	Anesth hernia repair, preemie	6	Agree	6
#00921	Anesth, vasectomy	3	Agree	3
#01829	Anesth, dx wrist arthroscopy	3	Agree	3
#01991	Anesth, nerve block/inj	3	Agree	3
#01992	Anesth, nerve block/inj, prone	5	Agree	5

*All CPT codes copyright 2003 American Medical Association.# New CPT codes.

Discussion of Codes for Which There Were No RUC Recommendations or for Which the RUC Recommendations Were Not Accepted

The following is a summary of our rationale for not accepting particular RUC work RVU or base unit recommendations. It is arranged by type of service in CPT order. Additionally, we also discuss those CPT codes for which we received no RUC recommendations for physician work RVUs. This summary refers only to work RVUs or base units.

New and Revised Codes for 2003

CPT code 17310 Chemosurgery (Mohs micrographic technique) including

removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathological preparation including the first routine stain (e.g., hematoxylin and eosin, toluidine blue); each additional specimen after the first 5 specimens, fixed or fresh tissue, any stage (List separately in addition to code for primary procedure).

This add-on code is used to report specimens generated during Mohs surgery. Prior to the changes made for 2003, the code was reported once for all specimens over five, generated during a particular stage of Mohs surgery. In 2003, the code will be used to report

each specimen over five during a particular stage of Mohs surgery. The RUC recommended maintaining 0.95 work RVUs for this code as an interim value. We disagree. We share the concerns of the RUC that the specialty society recommendation was based on a survey that did not take into account the ZZZ global period of this code. Additionally, in order to determine whether the current work RVU for 17310 was appropriate, we analyzed the current work RVU for 17310 in the context of the work RVUs for other Mohs surgery CPT codes. Mohs surgery work RVUs are based on Harvard data which is depicted in Table 8 below (all codes have 000 global periods for 2002):

TABLE 8

CPT code	2002 Work RVUs	Total time (minutes)	Intra-service time (minutes)	Work intensity (work RVU/total time)	RN Time (minutes) (CPEP data)	Histotechnician Time (minutes) (CPEP data)
17304	7.6	89	50	.085	202	50
17305	2.85	62		.046	101	25
17306	2.85	62		.046	101	25
17307	2.85	62		.046	101	25
17310	0.95	31		.031	32	8

These data clearly show that the Harvard data appropriately rank these services in terms of intensity. We note that, because intra-service times are not given for all codes, it is impossible to calculate intra-service work intensity. The RUC recommendation of 0.95 work RVUs which is based on a median time of 20 minutes yields a work intensity of 0.047 which is higher than the work intensities for CPT codes 17305–17307.

This would create a rank order anomaly in this family of codes.

We also note that the 2002 descriptor for CPT code 17310 says that this code should be reported only once for all specimens more than five for a given stage of Mohs. Therefore, we believe that the current work RVU represents the total work required for the typical number of specimens obtained (beyond five) per stage of Mohs.

We compared CPT code 17310 with CPT codes 88331 *Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen*, and 88332 *Pathology consultation during surgery; each additional tissue block with frozen section(s)*. CPT code 88332 has a work RVU of 0.59 and total physician time of 15 minutes. We note that if the RUC survey time (20 minutes) for CPT code 17310 is multiplied by the Harvard

intensity (.031) that a work value of 0.62 is obtained.

Therefore, we are assigning a work value of 0.62 work RVUs to CPT code 17310 pending further recommendations from the RUC. We believe this value is appropriate for the new descriptor, which allows reporting of CPT code 17310 for each specimen rather than once for all specimens. We also believe this work value places this code in correct rank order with CPT codes 17304–17307 and with CPT codes 88331 and 88332.

We also note that a work value of 0.62 RVUs will not require any work neutrality adjustment because it already takes our claims data for CPT code 17310 into account.

CPT Codes 21030, Excision of benign tumor or cyst of maxilla or zygoma, by enucleation and curettage, and 21040, Excision of benign tumor or cyst of mandible, by enucleation or curettage.

CPT changed the descriptors for these codes to make the procedure more specific, and we have not yet received RUC recommendations for these codes. We compared these services to CPT Codes 21555, *Excision tumor, soft tissue of neck or thorax; subcutaneous* (work RVU of 4.35), 28043, *Excision, tumor, foot; subcutaneous tissue* (work RVU 3.54), 28108, *Excision or curettage of bone cyst or benign tumor, phalanges of foot* (work RVU 4.16), 21501, *Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax* (work RVU 3.81), 26115 *Excision, tumor or vascular malformation, soft tissue of hand or finger; subcutaneous* (work RVU 3.86), and 24075 *Excision, tumor, soft tissue of upper arm or elbow area; subcutaneous* (work RVU 3.92). We believe that 21030 and 21040 are most similar to 24075 and 26115 in terms of physician work and are assigning interim RVUs of 3.89 for both of these procedures. We are crosswalking the malpractice RVUs from current CPT Code 21030 (0.60 RVUs) to these procedures.

CPT Codes 21740 Reconstructive repair of pectus excavatum or carinatum; open and 21742 Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) with thoracoscopy

We have not received the final recommendation from the RUC on these services and carriers will price these services in 2003.

CPT codes 33215 Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode and 33216 Insertion of transvenous electrode;

single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator

We received a RUC recommendation of 4.44 work RVUs for CPT code 33215 and a RUC recommendation of 5.39 work RVUs for CPT code 33216. Previously, both the insertion and repositioning of the electrodes were billed under CPT code 33216. Effective January 1, 2003, CPT code 33215 will be used to report the repositioning of a previously implanted transvenous pacemaker or pacing cardioverter-defibrillator electrode, while CPT 33216 will be used to report the insertion of a transvenous electrode. Although we agree with the relativity established by the RUC, in order to retain work neutrality between these two services, we have scaled the total relative values that will be paid in 2003 to what would have been paid in 2003 if CPT code 33215 had not been established. This results in work RVUs of 4.76 for CPT code 33215 and 5.78 work RVUs for CPT code 33216.

CPT Codes 36511 Therapeutic apheresis; for white blood cells, 36512 Therapeutic apheresis; for red blood cells, 36513 Therapeutic apheresis; for platelets, 36514 Therapeutic apheresis; for plasma pheresis, 36515 Therapeutic apheresis; with extracorporeal immunoabsorption and plasma reinfusion, and 36516 Therapeutic apheresis; with extracorporeal adsorption or selective filtration and plasma reinfusion

We have not yet received the RUC recommendations for these CPT codes. We are assigning 1.74 work RVUs to all these procedures. This is the work RVU for both CPT codes 36520 and 36521 (deleted for CPT 2003) which are currently being used to report these procedures. We are also crosswalking the malpractice RVUs for CPT code 36520 to these procedures (0.06 RVU).

CPT Codes 38204 Management of recipient hematopoietic progenitor cell donor search and cell acquisition, 38205 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic, 38206 Blood-derived hematopoietic cell harvesting for transplantation, per collection; autologous, 38207 Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage, 38208 Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, 38209 Transplant preparation of hematopoietic progenitor cells; washing of harvest, 38210 Transplant preparation of hematopoietic progenitor cells; specific cell depletion within

harvest, T-cell depletion, 38211 Transplant preparation of hematopoietic progenitor cells; tumor cell depletion, 38212 Transplant preparation of hematopoietic progenitor cells; red blood cell removal, 38213 Transplant preparation of hematopoietic progenitor cells; platelet depletion, 38214 Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion, 38215 Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer, 38242 Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions

We agree with the RUC work recommendations for CPT codes 38205, 38206, and 38242. We disagree with the RUC recommendations for the CPT code 38204. CPT codes 38207 through 38215 were reviewed at the April RUC meeting but final work RVUs were not established. We did not receive final recommendations on work RVUs for these services in time for publication in this final rule, but will review any RUC recommendations for next year.

CPT code 38204 is reported by the physician managing a search for potential hematopoietic progenitor cell donors. We are giving this code a status indicator “B,” meaning that we will not make separate payment for this service. We believe we are already making payment for any physician work associated with this service as part of our payment for other bone marrow transplant codes (that is, CPT codes 38205, 38206, 38240, 38241, and 38242). Furthermore, we have significant concerns about how this code would be used in actual practice. Would beneficiaries be billed for failed donor searches, and, if so, how many? How would beneficiaries be able to determine whether one or more searches had actually been conducted? This problem is compounded by the fact that the beneficiary would probably never meet the physician conducting the search. Additionally, it is unclear from the specialty society vignette what is actually physician work and what is the work of clinical and administrative staff. It would seem most appropriate that any payment would be made to the physician who is performing the cell harvesting or bone marrow transplant services (that is, CPT codes 38205, 38206, 38240, 38241, and 38242). We welcome RUC’s further review of these codes to determine whether any physician work associated with a cell donor search is already included. If the RUC determines that such work is not included, we would review

recommendation for changing the RUC values of these codes to include such work.

CPT codes 38207, 38208, 38209. These codes represent an unbundling of CPT codes 88240 *Cryopreservation, freezing and storage of cells, each cell line*, and 88241 *Thawing and expansion of frozen cells, each aliquot*. Both codes 88240 and 88241 are paid under the laboratory fee schedule. We also note that CPT 2003 has added a parenthetical note under 88240 and 88241, which implies that, starting in January 2003, they should be used only for diagnostic services, and codes 38207, 38208, and 38209 should be used for therapeutic services.

- It is unclear from the specialty vignettes whether any physician work is typically required to perform these services. The descriptions of typical physician involvement in these procedures indicate that the only physician services are laboratory oversight or quality management services for which we do not make separate payment to physicians.

- We also believe these services will be reported on a “per aliquot” basis. However, even though blood-derived stem cells are usually stored in aliquots, the processes of freezing, thawing, and washing are done in batches. This means that the physician oversight of these processes does not occur on a “per aliquot” basis and therefore, it does not seem appropriate to pay for physician services on a “per aliquot” basis.

- We believe that the analysis the RUC was using to arrive at its interim recommendation for assigning physician work to CPT codes 38207, 38208, and 38209 was flawed. The RUC discussed assigning physician work to these services based on its review of 38210 which it compared to CPT code 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (work RVU 0.94). The RUC then used the specialty societies’ relative ranking of services 38207–38215 as the basis for recommending work values for CPT codes 38207–38209 and 38211–38215. With regard to this analysis, we note: (1) the descriptor for CPT code 86077 requires a physician service and an “interpretation and written report,” while CPT code 38210 is not described as a physician service, nor does it require an “interpretation and written report.” Therefore, we believe it is inappropriate to compare 38210 with 86077, (2) 38210 is currently reported as CPT code 86915, *Bone Marrow or peripheral stem cell harvest, modification or treatment to eliminate cell types* (e.g., T cells, metastatic

carcinoma) which is paid under the laboratory fee schedule, and (3) 38207, 38208, and 38209 describe entirely different services from 38210, 86077, and 86915, thus making it difficult to understand how a work value for 38210 could be extrapolated to 38207–38209.

At this time we are assigning status indicator “I” to 38207–38209 making them not valid for Medicare purposes. We are creating two G codes, G0265 *Cryopreservation, freezing and storage of cells for therapeutic use, each cell line*, and G0266 *Thawing and expansion of frozen cells for therapeutic use, each aliquot*. These codes will be paid under the laboratory fee schedule at the same rate as CPT codes 88240 and 88241 respectively. The descriptors will allow us to continue to recognize CPT codes 88140 and 88141 as described in CPT 2003 for diagnostic use, thus making it unnecessary for us to change the status indicators for these services. The G codes will also enable us to track the utilization of these services. We believe that continuing the status quo with regard to these procedures will not affect beneficiary access to transplantation services and will give us more time to analyze the services and recommendations.

CPT codes 38210–38215. Currently CPT codes 38210–38213 are described by CPT code 86915, *Bone Marrow or peripheral stem cell harvest, modification or treatment to eliminate cell types* (for example, T cells, metastatic carcinoma). Currently, CPT code 86915 is paid under the laboratory fee schedule. With regard to CPT codes 38210–38215, we have many of the same concerns as we have for CPT codes 38207–38209.

- It is unclear from the specialty vignettes whether any physician work is typically required to perform these services. The descriptions of typical physician involvement in these procedures indicate that a significant portion of the physician work is procedure oversight or quality management services for which we do not make separate payment to physicians. In fact, the only references in the specialty society vignettes for these procedures to services paid under the physician fee schedule are references to performance of flow cytometry. Therefore, if there is any physician work associated with these services it is currently payable under the CPT code 88180 *Flow cytometry; each cell surface, cytoplasmic or nuclear marker*.

- We do not believe that unbundling of these services is warranted because CPT codes 38210, 38212, 38213, 38214, and 38215 may be performed together

on a single harvest of stem cells during an allogeneic transplant. Further, when these services are performed together, if there is any physician work associated with these activities, it must be allocated to each service and it is not clear that this can be accomplished.

- As discussed above, we have concerns about the RUC’s preliminary discussions for work RVUs for these codes. CPT code 86077 to which 38210 was compared requires physician services, an interpretation and report, and has forty minutes of intra-service time associated with it. In contrast 38210 has no requirement for physician work, and it is stated that the physician will only perform this service in an emergency. Further, there is no requirement for interpretation of data or a written report, and the intra-service time is 23 minutes. We do not believe the stress involved with these procedures is any greater than the stress involved with 86077 or other pathology services that require correct interpretation of clinical laboratory data or surgical specimens to make a correct diagnosis essential in determining appropriate treatment. Furthermore, we know the RUC is continuing to review these codes and we also require further time to review them.

Therefore, we are assigning status indicator “I” to CPT codes 38210–38215, making them invalid for Medicare purposes. We are creating G0267, *Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s)* (for example, T-cells, metastatic carcinoma). This G code will replace deleted code CPT code 86915, and it will be paid under the laboratory fee schedule.

We welcome any comments from the RUC or other interested parties concerning these codes and ask that such comments specifically address the concerns discussed above. We will continue to review these codes internally, obtain payment and utilization data for CPT code 86915, and track utilization of all three G codes.

CPT code 45335 Sigmoidoscopy, flexible; with directed submucosal injection(s) any substance and 45381 Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s) any substance

The RUC recommended work RVUs of 1.46 for CPT code 45335 and 4.30 for CPT code 45381. For CPT code 45335, the RUC used CPT code 45330 as the base code (0.96 work RVUs) and added an increment of 0.50 work RVUs based upon the increased pre-, intra-, and post-service work associated with CPT code 45335 as compared to CPT code 45330. For CPT code 45381, the RUC

used CPT code 45378 (3.70 work RVUs) as the base code and added an increment of 0.60 work RVUs based upon the increased pre-, intra-, and post-service work associated with CPT code 45381 as compared to CPT code 45378.

In order to review the RUC recommended values for CPT code 45335 and 45381, we compared these services to the analysis and recommendations provided by the RUC for CPT codes 43201 and 43236. We agree with the RUC recommendations for CPT codes 43201 and 43236, which are also new submucosal injection codes. We further note that the intra-service intensities of CPT codes 43201 and 43236 should be higher than the intra-service intensities of CPT codes 45335 and 45381 because of the increased risk of complications, and the fact that several sites are being injected instead of one.

In reviewing the pre-, intra-, and post-service times for CPT codes 43201, 43236, 45335, and 45381, we are unsure why these times vary so much. The pre-service time for CPT code 45381 is 25 minutes longer than the pre-service time for CPT code 45378 and there is nothing in the RUC vignette to indicate the reason for the increased pre-service time. Moreover, it is unclear why the post-service time for CPT code 45381 is 9 minutes less than the post-service time for CPT code 45378. Interestingly, less than 10 minutes of extra pre- and post-service time (beyond the base codes) was allotted for the incremental work of CPT codes 43201 and 43236 that we believe are more intensive procedures than CPT codes 45335 and 45381. Therefore, we believe that the pre- and post-service time increment for CPT codes 45335 and 45381 should be less than for CPT codes 43201 and 43236. In short, we had a great deal of difficulty interpreting the RUC time data.

In assigning work values to CPT codes 45335 and 45381, we compared them to the incremental work values and times for CPT codes 43201 and 43236 because we agreed with the RUC recommendations and times for those codes. The intra-service intensities for CPT codes 43201 and 43236 are 0.05 RVU per minute and 0.035 RVU per minute, respectively. We believe the intra-service intensity of CPT code 45335 is less than the intensity of CPT code 43201. After accounting for a few minutes of extra post-service time and an intra-service intensity of 0.04 RVU per minute, we are left with an incremental work value of 0.4 work RVUs for CPT code 43201, which is what we will apply to CPT code 45335.

We also believe the intensity of CPT code 45381 is less than the intensity of CPT code 43201. Therefore, accounting for approximately 10 minutes of extra pre- and post-service time, and assigning an intra-service intensity of 0.04 RVU per minute leaves an incremental work value of 0.5 work RVUs, which is what we will apply to CPT code 45381. Therefore, we are assigning work RVUs of 1.36 and 4.20 to CPT codes 45335 and 45381, respectively.

CPT code 45340 Sigmoidoscopy, flexible; with dilation by balloon, each stricture

The RUC recommended a work RVU of 1.96 for this CPT code. This includes 1.00 for the incremental work based on the need for conscious sedation to perform this procedure (other flexible sigmoidoscopies do not require conscious sedation). This means the incremental work for CPT code 45340 is greater than the incremental work for other endoscopic dilation codes (CPT codes 43245 and 45386) because those codes have base procedures that include use of conscious sedation. The RUC has been considering the issue of conscious sedation in general for some time and has not been able to conclude that there is any incremental physician work associated with conscious sedation. In the absence of a specific RUC recommendation affirmatively stating that specific physician work is associated with conscious sedation, we do not believe it is appropriate to assign a work RVU for CPT code 45340 that is based on the presumption that a portion of the work value is for using conscious sedation. Therefore, we compared the RUC recommendations for work and physician time for CPT code 45386 to the incremental times for CPT code 45340. We believe that the intra-service intensity of CPT code 45340 should be no greater than the intra-service intensity for CPT code 45386. Therefore, we calculated the increment in pre- and post-service work (.341 work RVUs) and the intra-service intensity (0.036 RVU per minute) of CPT code 45386. We multiplied this intensity by 10 minutes to arrive at an intra-service work of .36 RVU for CPT code 45340 and added .341 RVUs for pre- and post-service work to arrive at an RVU of 0.7 for the total incremental work of CPT code 45340. Therefore, we are assigning an interim work RVU of 1.66 to CPT code 45340.

CPT code 46706 Repair of Anal Fistula with fibrin glue. The RUC recommended 2.95 work RVUs for this service based on a comparison to CPT codes 46020, *Placement of Seton* (work RVU 2.90) and 46940, *Curettage or*

Cautery of Anal Fissure, including dilation of anal sphincter (separate procedure); initial (work RVU 2.32). The intra-service time for CPT code 46706 is less than the intra-service time for CPT code 46940 and requires similar physician work to CPT code 46612, *Anoscopy with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique* (work RVU 2.34). The post-service work for CPT code 46706 is comparable to that of CPT code 46940. Therefore, we are assigning a work RVU of 2.39 to CPT code 46706. Malpractice RVUs are crosswalked from CPT code 46940 at 0.17 RVUs.

CPT code 51798 Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, nonimaging. The RUC recommended 0.38 work RVUs based on a comparison of this procedure to CPT code 76857, *Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete.* The RUC recommended 0.38 work RVUs based on a urology survey that reported that this procedure is performed 75 percent of the time by the physician and based on a comparison of this procedure to CPT code 76857, *Ultrasound, pelvic (nonobstetric, B-scan and/or real time with image documentation; complete.* We disagree. This code has been a HCPCS level two code that was assigned 0.00 work RVUs because we believe that it is typically performed by a nurse or other clinical staff. We continue to believe that this is a non-physician service and are assigning 0.00 work RVUs to this service. We will accept the practice expense inputs recommended by the RUC and will crosswalk the malpractice RVUs from G0050. It is not appropriate to bill CPT code 51798 in a SNF, hospital, or other setting in which nursing care is provided by the facility, since it is a routine nursing service, not really a diagnostic test.

CPT code 75954 Endovascular graft placement for repair of iliac artery (for example, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) radiological supervision and interpretation.

The RUC agreed with the specialty societies and recommended a value of 2.93 work RVUs based on comparing this code to CPT code 75952, *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* (work RVU of 4.5) and CPT code 75953, *Placement of proximal or distal extension prosthesis for endovascular repair of infra renal abdominal aortic aneurysm, radiological supervision and*

interpretation (work RVU or 1.36). The recommended RVUs are midway between the RVUs of the reference procedures. The specialty societies presented the following to the RUC: "Unlike many of the other radiological supervision and interpretation (S&I) codes, 75954 includes all routine supervision and interpretation of the endovascular iliac graft placement procedure with the only exception being that 75953 is added if an extension prosthesis is required. This more inclusive approach makes 75954 very similar in concept to the inclusive S&I for endovascular aortic aneurysm repair CPT 75952." The specialties go on to say that survey respondents believed that the code should be valued less than CPT code 75952 but more than CPT code 75953. We disagree. First, we note that CPT code 75953, which was reviewed by the RUC in February of 2001, is not an "add-on" code. It is a stand-alone code that is billed with a stand-alone surgical procedure. Furthermore, total procedure time for CPT code 75954 (85 minutes) is less than the total procedure time for CPT code 75953 (95 minutes), and the intra-service times of CPT codes 75954 and 75953 are identical (45 minutes). This is consistent with the specialty societies' description of the work of CPT code 75954, which is virtually identical to the description of the work for CPT code 75953. Therefore, in order to maintain correct rank order in this family of codes we are assigning a work RVU of 1.36 to CPT code 75954.

CPT codes 92605 Evaluation for prescription of non-speech generating augmentative and alternative communication device and 92606 Therapeutic service(s) for the use of non-speech generating device, including programming and modification

We will consider CPT codes 92605 and 92606 bundled for Medicare payment purposes. The RUC's evaluation of these services implied that they are similar to the new CPT codes for speech generating devices. We believe that CPT codes 92605 and 92606 typically do not involve the same type of highly specialized equipment as the codes for speech generating devices. We believe that the work associated with these services is already contained in CPT codes 92506 *Evaluation of speech, language, voice communication, auditory processing, and/or aural rehabilitation status* and 92507 *Treatment of speech, language, voice communication, auditory processing disorder (includes aural rehabilitation); individual*, and will consider CPT codes 92605 and 92606 bundled.

We note that CPT also created new codes to describe programming and analysis of cochlear implants. These CPT codes are 92601 *Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming*; 92602 *Diagnostic analysis of cochlear implant, patient under 7 years of age; subsequent reprogramming*; 92603 *Diagnostic analysis of cochlear implant, age 7 years or older, with programming*; and 92604 *Diagnostic analysis of cochlear implant, age 7 years or older, subsequent reprogramming*. Codes 92601 and 92603 describe post-operative analysis and fitting of previously placed external devices, connection to the cochlear implant, and programming of the stimulator. CPT Codes 92602 and 92604 describe subsequent sessions for measurements and adjustment of the external transmitter and re-programming of the internal stimulator.

An existing CPT code, 92510 *Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming*, will no longer be used for Medicare services since it represents services which have considerable overlap with the services described by the new CPT codes, 92601, 92602, 93603, and 92604. For the remaining services that do not involve reprogramming of the cochlear implant, CPT code 92507 *Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual* describes the services, so a code specific to cochlear implant patients is no longer needed. The use of CPT code 92507 for this service is consistent with the note in the CPT manual under CPT code 92602.

CPT codes 92613 Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; physician interpretation and report only, 92615 Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; physician interpretation and report only, and 92617 Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; physician interpretation and report only.

Effective January 1, 2003, CPT created several codes to describe fiberoptic endoscopic evaluation services that are currently described by temporary G-codes. For specific information related to both the former G-codes and the new CPT codes that will replace the deleted G-codes, refer to the end of this section. We agreed with the RUC recommended

values for all of the fiberoptic endoscopic evaluation services (CPT codes 92612, 92614, and 92616) with the exception of CPT codes 92613, 92615, and 92617. For these three services that refer only to a separately identified physician review and interpretation of the fiberoptic endoscopic evaluation, we consider the physician interpretation and report bundled into an evaluation and management service. We believe the physician who does not perform the testing should only bill the patient when performing an evaluation and management service, not as the supervisor of another professional performing and reviewing the initial fiberoptic endoscopic evaluation. The interpretation of this test is an integral part of the testing itself. If a nonphysician professional has the credentials and experience to perform this testing, then that professional should also provide the interpretation of the findings.

CPT codes 93784 Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report, 93786 Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only, 93788 Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report, and 93790 Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report.

We have not yet received RUC recommendations for these codes. We established RVUs for these services during this past year in response to a national coverage determination. We will maintain these RVUs until we receive a RUC recommendation.

CPT code 95990 Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular).

We understand that performance of CPT code 95990 requires the use of an expensive kit, the cost of which may not be reflected in the RVUs for CPT code 96530, the code under which it was previously reported. CPT code 96530 has practice expense RVUs of 1.01 and malpractice RVUs of 0.05. We are assigning 1.50 practice expense RVUs because we estimate that the practice expense for CPT code 95990 is 50 percent higher than it is for CPT code

96530. We are crosswalking the malpractice RVUs from CPT code 96530 to CPT code 95990.

We are not assigning work RVUs to CPT code 95990 for 2003 since we believe that this procedure is typically (greater than 50 percent of the time) performed by a nurse. We understand that there has been discussion with the CPT Editorial Committee about revising this code so that it would be billed only when performed in the presence of a physician. If the code were to be so revised, we would consider any RUC recommendations regarding work RVUs for this service.

These values are interim for 2003 and we will address comments about the RVUs for this code in next year's final rule.

CPT codes 99026 Mandated On-call service; in hospital and 99027 Mandated physician on call services

No RUC recommendation was received for these codes. Note that stand-by and on-call services are not covered by Medicare and we would not pay for these services billed using these codes.

Establishment of Interim Practice Expense RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2003

We have developed a process for establishing interim practice expense RVUs for new and revised codes that is similar to that used for work RVUs. Under this process, the RUC recommends the practice expense direct inputs, that is, the staff time, supplies and equipment, associated with each new code. We then review the recommendations in a manner similar to our evaluation of the recommended work RVUs.

The RUC recommendations on the practice expense inputs for the new and revised 2003 codes were submitted to us as interim recommendations. We, therefore, consider that these recommendations are still subject to further refinement by the PEAC, or by us, if it is determined that such future review is needed. We may also revisit these inputs in light of future decisions of the PEAC regarding supply and equipment packages and standardized approaches to pre- and post-service clinical staff times.

We have accepted, in the interim, all of the practice expense recommendations submitted by the RUC for the codes listed in the following table titled "AMA RUC and HCPAC RVU Recommendations and CMS

Decisions for New and Revised 2003 CPT Codes."

C. Other Changes to the 2003 Physician Fee Schedule

We are establishing the following HCPCS codes for CY 2003.

GO262 Small intestinal imaging; intraluminal, from ligament of Treitz to the ileo cecal valve, includes physician interpretation and report

We are creating this code to describe a new diagnostic test for which we will make separate payment under the physician fee schedule and the Hospital Outpatient Prospective Payment System (OPPS). The procedure involves ingesting a small camera through the mouth. As the camera traverses the gastrointestinal tract, it produces two images per second and transmits those images to a receiver worn by the patient. After eight hours (the battery life of the camera) the belt containing the receiver is removed from the patient. The images are then developed and reviewed by a physician who interprets them and makes a written report. The capsule is excreted in the patient's stool and discarded. Images taken in the esophagus, stomach and large intestine (colon) are hard to interpret; therefore, current use of this imaging modality is limited to evaluation of the small intestine. The G-code descriptor is designed to ensure accurate reporting of this diagnostic test. Although this test has been referred to as "capsule endoscopy", the term "endoscopy" is a misnomer because "endoscopy" refers to physician-controlled viewing the gastrointestinal tract through an endoscope.

Physician Work

We understand from recently published clinical studies that the average small intestine transit time was 257 minutes and the transit time from ingestion to the cecum was 302 minutes. Review of the images includes a first pass overview to mark areas of special interest, a review of the entire video recording, and a focused review of abnormalities, if any are found. The average time to review the capsule images in two recently published studies was 50 and 56 minutes. Therefore, we believe that, typically, 53 minutes of physician time will be spent reviewing the video. To assign a work value, we compared the work of this code to the work of other diagnostic tests and procedures that require review of significant amounts of data. Specifically, we reviewed the work RVUs and intra-service times for electroencephalography (EEG) reading and interpretation, magnetic resonance

angiography (MRA), computed tomographic angiography (CTA), Holter monitor reading and interpretation, prolonged esophageal acid reflux testing, echocardiography, duplex scanning of the carotid arteries, and anorectal manometry. Based on these comparisons, we are assigning a work value of 2.12 RVUs. This results in an intensity of .04 RVU per minute and places it in correct rank order with the procedures to which it was compared. We note that this assumes that a complete study from the ligament of Treitz to the ileocecal valve was performed and that the camera functioned normally throughout the procedure and produced two images per second. If an incomplete evaluation of the small intestine is accomplished, this code should be billed with a CPT code 52-modifier indicating reduced services, and the payment amount would also be reduced. The amount of reduction is determined by the carrier. Until such time as we make a NCD for this service, coverage is at the discretion of carriers and intermediaries.

Malpractice

We are crosswalking the value from CPT code 74230 with the same PC/TC split because they have similar physician times and intensities.

Practice Expense

For the physician fee schedule we are assigning the following inputs for practice expense:

- Staff Time—RN/LPN/MA mix—90 minutes—includes pre-service education, attachment of the receiver, administration of the camera, removal of the receiver, and processing of the images

- Supplies—Single use camera; Razor
- Equipment—Workstation

GO268 Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing

This code was created in order to allow payment to a physician who removes impacted cerumen on the same date as his or her employed audiologist performs audiologic function testing. We will assign the same physician work RVUs, practice expense inputs, and malpractice RVUs to this code as are assigned to CPT code 69210, *Removal impacted cerumen (separate procedure), one or both ears*.

First, we emphasize that routine removal of cerumen is not paid separately. It is considered to be part of the procedure with which it is billed (for example, audiologic function testing). To assure the appropriate reporting of this code, we note that it

should only be used in those unusual circumstances when an employed audiologist who bills under a physician UPIN number performs audiologic function testing on the same day as removal of impacted cerumen requiring physician expertise for removal. This code should not be used when the audiologist removes cerumen, because removal of cerumen is considered to be part of the diagnostic testing and is not paid separately.

GO269 *Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (for example, angiaseal plug, vascular plug)*

We are creating this G code to assure proper reporting of this service. It has come to our attention that this service is being inappropriately reported with codes for such procedures as "blood vessel repair" and "repair of arterial pseudoaneurysm." We are assigning a status indicator of "B" (payment bundled into payment for other services) to this service, as the work, practice expense, and malpractice risk of closing an arteriotomy or venotomy site at the conclusion of an invasive percutaneous procedure, whether by manual compression, suture, or use of a closure device, is included in the main invasive procedure. Therefore, there is no separate payment for this procedure.

GO270 *Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes and*

GO271 *Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) group (2 or more individuals), each 30 minutes*

In our NCD dated May 1, 2002, we established basic coverage for medical nutrition therapy billed under CPT codes 97802 through 97804 as 3 hours per year for beneficiaries with either diabetes or renal disease. However, we also pay for additional hours if a physician makes a second referral in the same year based on a change in the beneficiary's medical condition, diagnosis, or treatment regimen. These new codes allow us to edit for basic coverage and reimburse for additional coverage when appropriate.

We are crosswalking the RVUs from CPT code 97803 to G0270 and CPT code 97804 to G0271 because these are the

corresponding CPT medical nutrition codes.

GO272 *Naso/oro gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)*

We are creating this code for one year until an identical CPT code becomes effective.

Physician Work

We compared this code to other gastroenterology and radiologic procedures including CPT codes 91105 *Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poisons)* (work RVU of 0.37); 44500 *Introduction of long gastrointestinal tube (e.g., Miller-Abbott) (separate procedure)* (work RVU of 0.49); 74340 *Introduction of long gastrointestinal tube (e.g., Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation* (work RVU of 0.54), and 76000 *Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (e.g., cardiac fluoroscopy)* (work RVU of 0.17).

This procedure is most similar to CPT code 91105 (16 minutes of physician time), but requires less work because it is done in a controlled setting with fluoroscopy to aid in placement. It is not similar to CPT codes 44500 and 74340 because placement of Miller-Abbott tubes is a more lengthy and involved procedure than placement of naso/oro gastric tubes. In fact, the physician time for placement of Miller-Abbott tubes is over 30 minutes, while placement of a naso/oro gastric tube takes about 15 minutes. We are assigning this G code a work RVU of 0.32, which is the sum of the work RVU for CPT code 76000 and the work intensity of CPT code 44500 times 15 minutes.

Malpractice

We are assigning 0.02 malpractice RVUs to this procedure.

Practice Expense

We believe this procedure will only be performed in facilities, so we are not assigning any practice expense inputs to this code.

GO273 *Radiopharmaceutical biodistribution, single or multiple scans on one or more days, pre-treatment planning for radiopharmaceutical therapy of non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies).*

We are creating this code to describe radionuclide scanning to determine the

biodistribution of Zevalin. The procedure encompasses administration of Indium labeled Zevalin followed by whole body radionuclide scanning 2–24 hours and 48–72 hours after the administration of Zevalin. Rarely, a third scan is necessary. The purpose of the scanning is to ensure that the biodistribution of Zevalin is normal, thus decreasing the risk of toxic effects from the administration of a therapeutic dose. The published criteria for determining appropriate biodistribution involve making a qualitative comparison of isotope uptake in several organ systems between the two scans. Therefore, these scans cannot be read in isolation, and this code should only be reported once, no matter how many scans are performed.

Physician Work

We are assigning 0.86 work RVUs to this code which is equivalent to the work for CPT code 78802, *Radiopharmaceutical localization of tumor; whole body*. We believe the total physician time of 41 minutes for CPT code 78802, and the intensity are similar to the time and intensity required for this service.

Malpractice

We are assigning 0.28 RVU to the global procedure, 0.25 RVU to the technical component, and 0.03 RVU to the professional component. These are identical values to CPT code 78802.

Practice Expense

The TC of this code is being priced in the nonphysician work pool, where we crosswalked it to the charge-based practice expense RVUs for CPT code 78802, taking into account that the radiopharmaceutical is administered once, but that there are two scans obtained.

We wish to emphasize that this code is only reported once and includes the administration of the radiopharmaceutical and performance and interpretation of all scans. We also note that the infusion of rituxumab prior to the administration of Zevalin is separately payable.

GO274 *Radiopharmaceutical therapy, non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)*

We are establishing this code to allow appropriate reporting of this new service. Radiopharmaceutical therapy using radiolabeled monoclonal antibodies is a new form of treatment for non-Hodgkins lymphoma and is not currently described by any existing HCPCS code.

After review of information regarding this service, we are assigning the following RVUs:

Physician Work

We believe that physicians typically take 60 minutes to perform this service on the day of the procedure. Of this time, 45 minutes is spent counseling the patient and family, while 15 minutes are spent setting up and infusing the radiopharmaceutical. Additionally, there is post-procedure time spent reviewing platelet counts, which requires calling the patient or another physician 25 percent of the time. We compared this procedure to the physician work RVUs, physician times, and intensity (RVU per minute) of other nuclear medicine and radiation oncology procedures CPT codes 79400, 77790, 79030, 79035, and 79100; infusion procedures CPT codes 36520, 36521, 37201, and 37202; hemodialysis CPT codes 90935, and 90937; evaluation and management CPT codes 99214 and 99215.

Based on this comparison we are assigning a work RVU of 2.07 to this code. This represents the work of CPT code 99214 (counseling a complex patient), 15 minutes for infusion at an intensity of 0.05 RVU per minute (similar to the intensity of CPT code 77790), and 10 minutes of post service work (at an intensity of 0.022 RVU per minute). This also places the code in the correct rank order with all of the above procedures.

Malpractice

We are assigning malpractice RVUs of 0.20 to this procedure, with 0.12 assigned to the technical component and 0.08 assigned to the professional component. These are identical to the RVUs for CPT code 79400.

Practice Expense

The TC of this code is being priced in the nonphysician workpool where we crosswalked it to the charge-based practice expense RVUs for CPT code 79400.

GO275 *Renal angiography (unilateral or bilateral) performed at the time of cardiac catheterization, includes catheter placement in the renal artery, injection of dye, flush aortogram and radiologic supervision and interpretation and production of images (List separately in addition to primary procedure) and*

GO278 *Iliac artery angiography performed at the same time of cardiac catheterization, includes catheter placement in the iliac artery, injection of dye, radiologic supervision and interpretation and production of images*

(List separately in addition to primary procedure)

We are creating these add-on codes to assure proper reporting of and payment for renal and iliac angiography performed at the time of cardiac angiography. These procedures are performed frequently on Medicare patients and are currently reported using codes that describe placement of a catheter in the renal and/or iliac artery(s) (CPT codes 36245 and 36246) and radiological supervision and interpretation of renal and/or iliac angiography (CPT codes 75710, 75716, 75722, and 75724).

Physician Work

Based on the information we reviewed, the typical performance of these procedures involves the use of a pigtail catheter positioned in the aorta (not the renal or iliac artery(s)), injection of a minimal dye load (because of the heavy dye load already used for cardiac angiography), and viewing the dye run off into the proximal main renal or iliac arteries under fluoroscopy. We determined work values for these procedures by using the work values for CPT codes 75625, *Aortography, abdominal, by serialography, radiological supervision and interpretation* (1.14 work RVUs with 22 minutes of physician time) and 93544, *Injection procedure during cardiac catheterization; for aortography* (0.25 work RVUs and 5 minutes of physician time) and adjusting for a procedure time of approximately two and one half minutes. This process yields a value of 0.25 work RVUs, which is what we are assigning to these two add-on procedures.

Malpractice

We are crosswalking the 0.01 malpractice RVUs for CPT code 93544 to these procedures.

Practice Expense

We are not assigning any practice expense inputs to these procedures because the incremental increase in staff and room time to perform these procedures is negligible.

GO279 *Extracorporeal shock wave therapy; involving elbow epicondylitis.*

GO280 *Extracorporeal shock wave therapy; involving other than elbow epicondylitis or plantar fasciitis.*

CPT code 0020T *Extracorporeal Shock Wave Therapy; involving plantar fascia*

We are creating and establishing a national payment amount for two G-codes describing extracorporeal shock wave therapy for the musculoskeletal system and establishing a national

payment amount for CPT code 0020T. We are doing this in response to multiple requests from our contractors to establish a national payment amount, though creation of these codes does not imply that services will be covered by Medicare. We also note that this form of therapy was recently approved by the Food and Drug Administration for treatment of lateral epicondylitis. Our staff has reviewed the method of treatment and we are establishing work, practice expense, and malpractice RVUs for these codes.

We believe these services are similar to other physical therapy modalities and are designating it to be paid on the therapy fee schedule. Based on the information we reviewed, these services are typically performed by a technician similar to a physical therapy aide and take about 20 minutes to perform.

Physician Work

We compared these services to other physical therapy services and believe they are most similar to unattended physical therapy modalities such as diathermy. We are assigning a work RVU of 0.06 for these procedures in order to place them in proper rank order with other unattended physical therapy services.

Malpractice

We are crosswalking the malpractice RVUs (0.01) from CPT code 97024, *Application of a modality to one or more areas; diathermy*, to these procedures.

Practice Expense

We are assigning the following practice expense inputs:

- Staff/Time: Physical therapy aide; 30 minutes.
- Supplies: Ultrasound Gel.
- Equipment: Shock wave machine.

We note that, for lateral epicondylitis, the typical treatment regimen is up to 3 total treatments at weekly intervals.

Electrical Stimulation for Wound Care

GO281 *Electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care; and*

GO282 *Electrical stimulation, (unattended), to one or more areas, for wound care other than described in GO281 and*

GO283 *Electrical stimulation, (unattended), to one or more areas, for indication(s) other than wound care, as part of a therapy plan of care.*

These three new G codes have been created to implement the coverage determination on use of electrical stimulation for wound care.

The work, practice expense, and malpractice values for CPT code 97014 *Application of a modality to one or more areas; electrical stimulation (unattended)* will be crosswalked to these new G codes, but G0282 will not be covered by Medicare. In addition, CPT code 97032, *Application of a modality to one or more areas: electrical stimulation (manual), each 15 minutes*, should not be utilized for any wound care.

The coverage determination that allowed coverage for the use of electrical stimulation for certain types of wound care also stated that another similar modality, electromagnetic stimulation, would not be covered. A G code, "G0295: *Electromagnetic stimulation, to one or more areas*" will be created to describe this service, since this service would otherwise have been coded using CPT code 97039 and would have required manual claims review. The new code, G0295, will be listed as non-covered by Medicare.

G0288 *Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery.*

We are creating this code to assure accurate reporting of this service by independent diagnostic testing facilities (IDTFs) that perform this service. Facilities that perform this service (either at the facility or under arrangement) report this service through the use of a "C" code specific to hospital reporting.

This code is a technical component code only since the service provided by the IDTF includes receipt of a Computed Tomographic Angiogram (CTA), post CTA processing using specialized software, and burning the 3D model onto a CD and returning it to the operating surgeon. This 3D model is used to assist vascular surgeons in planning for, or monitoring the results of, endovascular aneurysm repair. The service is a technical service provided under the general supervision of a physician according to the supervision requirements for IDTFs. We compared this procedure to CPT codes 74175, *Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing* and 76375, *Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computerized axial tomography, magnetic resonance imaging, or other tomographic modality*. Based on this review, we developed practice expense

RVUs using the nonphysician workpool methodology. The malpractice RVUs will be crosswalked from CPT code 76375 directly and will be set at 0.15 RVUs.

G0289 *Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee.*

We are creating this code to permit appropriate reporting of arthroscopic procedures performed in different compartments of the same knee during the same operative session. This is an add-on code and should be added to the knee arthroscopy code for the major procedure being performed. This code is only to be reported once per extra compartment, even if both chondroplasty, loose body removal, and foreign body removal are performed. The code may be reported twice (or with a unit of two) if the physician performs these procedures in two compartments in addition to the compartment where the main procedure was performed.

This code should only be reported if the physician spends at least 15 minutes in the additional compartment performing the procedure. It should not be reported if the reason for performing the procedure is due to a problem caused by the arthroscopic procedure itself. This code is to be used when a procedure is performed in the lateral, medial, or patellar compartments in addition to the main procedure. However, CPT codes 29874, *Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)* and 29877 *Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)* may not be billed with other arthroscopic procedures on the same knee.

Physician Work

We examined the work RVUs, the intra-operative work intensity, and the intra-operative times for CPT codes 29874 and 29877. We also compared these intensities and times to those for CPT code 29870, the base procedure for this family. We determined a work value using the intra-operative intensity for CPT code 29874 (which is higher than for CPT code 29877) and the mean intra-operative times (for CPT codes 29874 and 29877) beyond the time required for CPT code 29870 (14 minutes for CPT code 29874 and 27 minutes for CPT code 29877). This code represents approximately 20 minutes of extra work at a high level of intensity. Therefore, the work value we are assigning to this code is 1.48 RVUs.

Malpractice

We are assigning 0.27 malpractice RVUs to this procedure. This is the sum of the malpractice RVUs for CPT codes 29874 and 29877 beyond the malpractice RVUs for CPT code 29870, divided by two.

Practice Expense

We are not assigning any practice expense inputs to this code because it is an add-on code that will only be performed in the facility setting.

Revisions to G Codes

We are also revising the descriptors for the following existing G codes as follows:

G0179 *Physician recertification services for Medicare-covered services provided by a participating home health agency (patient not present) including review of subsequent reports of patient status, review of patient's responses to the OASIS assessment instrument, contact with the home health agency to ascertain the follow-up implementation plan of care, and documentation in the patient's office record, per certification period* and

G0180 *Physician certification services for Medicare-covered services provided by a participating home health agency (patient not present), including review of initial or subsequent reports of patient status, review of patient's responses to the OASIS assessment instrument, contact with the home health agency to ascertain the initial implementation plan of care, and documentation in the patient's office record, per certification period*

Comment: Individuals have requested clarification as to whether a review of OASIS data is required when a physician bills for the certification and re-certification of home health plans of care.

Response: The review of OASIS data, although not required for the performance of either a certification or re-certification of a home health plan of care, is considered a valuable tool to be utilized in the performance of both a certification or re-certification of a home health plan of care. We agree that the current HCPCS code(s) descriptors are unclear and will revise the descriptors to identify the review of OASIS as an option as opposed to a requirement. The descriptors are being revised as follows:

G0179 *Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial*