

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

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

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

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

#### f. Practice Expense Advisory Committee (PEAC)

##### Recommendations on CPEP Inputs for 2004

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

the recommendations before the final rule.

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

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

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

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

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