

outdated because they were based on old data; for example, 1990 decennial census data and 1996 through 1998 malpractice premiums, the most recent data available when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 This should address the criticism of the 2001 through 2003 GPCIs being out of date.

a. Proposed Work Geographic Practice Cost Indices

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

b. Proposed Practice Expense Geographic Practice Cost Indices

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

c. Proposed Malpractice Geographic Practice Cost Indices

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

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

9. Payment Localities

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

C. Coding Issues

1. Payment Policy for CPT Tracking Codes

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

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

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

2. Excision of Benign and Malignant Lesions

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

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