

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

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

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

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

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

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

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

TABLE 4

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

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

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

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

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

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

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

6. Extracorporeal Shock Wave Lithotripsy for Musculoskeletal Conditions

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

7. Late RUC recommendations for 2003 CPT codes.

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

III. Other Issues

A. Rebasing and Revising of the Medicare Economic Index

1. Background

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