

6. Adjustments to RVUs To Match the New MEI Weights

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

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

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

TABLE 10

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

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

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

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

B. Definition of Diabetes for Diabetes Self-Management Training

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

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

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

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

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