

survey in next year's proposed rule at the same time we show the effect of the above described change for pathology services.

*c. Practice Expense for a professional component service*

While we typically assign all staff, equipment and supply costs for services with professional and technical components (PC and TC) to the technical portion of the service, in the proposed rule we discussed limited instances where it is appropriate to assign direct inputs to a PC service. We proposed to modify the practice expense methodology to allow direct inputs to be added to PC services when these inputs are clearly associated with the professional service, including when the PEAC makes such recommendations. Specifically we proposed to add the PEAC recommended staff times to the PC of the following cardiac services: CPT codes 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533 and 93624.

*Comment:* The RUC, the AMA, the American College of Physicians and societies representing cardiologists, cardiac rhythm specialists, interventional radiologists, nuclear medicine, chest physicians, radiation oncologists, radiologists, endocrinologists and dermatologists expressed support for this change in methodology. Commenters were also in agreement with the specific CPT codes mentioned in the proposed rule, but requested that direct inputs also be added to the PC of CPT codes 93619, 93620 and 93642, which were reviewed at the January PEAC meeting. The RUC comment indicated that additional codes might be identified at future PEAC/RUC meetings.

*Response:* We will finalize the proposed assignment of direct practice expense to the proposed 14 cardiac services and will add the PEAC recommended inputs to the PC of CPT codes 93619, 93620 and 93642, as requested by the commenters.

*d. Utilization Data*

We use Medicare utilization data in the development of specialty-specific practice expense RVUs that are then weight averaged to determine a single practice expense RVU per code. Prior to 2003, we used the most recent complete year of utilization data to determine the practice expense RVUs. 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 August

15, 2003 rule we proposed 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. Since we will not have any utilization data at the time we first establish practice expense RVUs for a new code, we proposed 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.

*Comment:* The specialty societies representing internal medicine, rheumatology and pulmonary medicine supported our proposal to use 1997 through 2000 Medicare utilization data for all codes that were in existence at that time and to use specialty-specific Medicare utilization data for codes created after 2000 when utilization data first become available, using the "all physician" average when we do not have sufficient information to assign a given specialty. These commenters, as well as several others, suggested that the RUC and the specialty societies could 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. However, a specialty society representing gastroenterology expressed concern that we are moving forward with plans to shift the basis of our methodology for compiling data to a five-year basis. The commenter urged us to not make changes until extensive impact comparisons are conducted that can be evaluated by physician community.

*Response:* We will implement our proposal to use specialty-specific Medicare utilization data for codes created after 2000 at the first opportunity they become available to us. We will also 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. Information about the specialty we assign to a code that has no utilization data can be found in the utilization data files we make available on the CMS web site following final rule publication. With respect to the comment about shifting to a 5-year basis of utilization data for the practice expense methodology, we are making no change in policy for codes that existed in the 1997 to 2000 period. We are using only the later year utilization data for

codes that have been created since that time. Any information from the RUC that could assist us in this process would be welcomed.

*Comment:* A specialty society representing colon and rectal surgeons agreed with our general utilization methodology, but disagreed that averaged 1997–2000 utilization data should be used for all codes that were not in existence for the entire period. The commenter argued that the frequency for these codes might be artificially low because the coding was new and that this may impact the relativity between new and old codes in the same family with similar inputs. The society suggested that any code that did not exist during the entire 1997–2000 period default to 2002 or most recent data.

*Response:* As we have explained, the Medicare utilization is important to the practice expense methodology because it determines which specialty scaling factors will be applied to the estimated practice expense input values in determining the practice expense RVUs for each service. The proportion of the volume billed by each specialty is more important to determining the practice expense RVU for a given service than the total volume. If the code is low in volume but the proportion of the code's volume billed by each specialty is generally consistent over time, there will be little or no difference in a code's practice expense RVUs, whether we use its initial year of utilization or a later year to determine its value.

*Comment:* Commenters representing dermatology as well as a pharmaceutical company expressed concern regarding the decrease in payment for photodynamic therapy, CPT code 95657. The commenters noted our discussion in the proposed rule indicating that this reduction in the practice expense RVUs is occurring because of updates to the Medicare utilization data used in the practice expense methodology. As a result of the updated utilization data, the practice expense methodology now uses the dermatology scaling factor (0.54) for supplies instead of the all physician average (1.29), and this change leads to the reduction in payment for the code. The commenters urged us to reconsider the proposal and at least to reinstate physicians' ability to bill separately in 2004 for the light-activating agent under the appropriate J code and also to remove the drug from the practice expense portion of the procedure.

*Response:* One of the functions of the utilization data in our practice expense methodology is to assign all procedures to the specialty-specific cost pools of the