

specialty or specialties performing them. Each cost pool has its own scaling factor. This scaling factor is used to scale the aggregate CPEP procedure-level costs for a specialty to the aggregate costs for the same specialty as determined by the SMS practice expense data. As we indicated in the proposed rule, we do not have utilization data upon which to determine the practice expense RVUs for a new code at the time it is created. As a default, we have assigned many new codes the "all physician" scaling factor until we have the data to move these codes into the appropriate specialty cost pools. Because it allows us to apply the appropriate specialty scaling factor, the use of the updated utilization data in the practice expense methodology can lead to increases or decreases in the value of a code, even though its practice expenses remain unchanged. In this case, the supplies scaling factor for dermatology is lower than that for "all physicians," leading to a decrease in practice expense RVUs when the dermatology scaling factor was applied to the CPEP data of the photodynamic therapy service.

We believe the initial practice RVUs for photodynamic therapy were too high, because the later information on Medicare utilization indicates that we should have used the dermatology scaling factor which would have produced a lower practice expense value. As we indicate above, we are working to minimize changes that will occur in the practice expense RVUs for a service by making an initial assumption about which specialty will likely bill us for a service. However, we believe our policy for new codes should be consistent with how we determine the practice expense RVUs for existing codes, even if updates to the Medicare utilization data lead to increases or decreases in the practice expense RVUs.

Though we believe that it is appropriate to use the updated utilization that results in a reduction in payment for CPT code 96567, we will pay separately for the light activating agent beginning January 1, 2004. However, we are also further considering whether Medicare should pay separately for certain topical drugs in certain circumstances. Any change in policy would be discussed in future rulemaking.

*Comment:* Specialty societies representing radiation oncology, as well as individual commenters, expressed concern about the decrease in payment for the intensity modulated radiation therapy (IMRT) treatment service, CPT code 77418. The commenters stated that this was due to a "quirk" in the

utilization data relating to new codes and requested that this code be priced by the non-physician work pool methodology.

*Response:* We will calculate the practice expense RVUs for the IMRT treatment service, CPT code 77418, using the nonphysician workpool methodology. This will be consistent with the way we currently calculate the practice expense for all other radiation therapy services with no physician work RVUs.

*Comment:* The specialty society representing radiation oncology also noted that there was a reduction in the practice expense RVUs for the intensity modulated radiation therapy planning procedure, CPT code 77301. A remote cardiac monitoring service questioned why the use of new utilization data could decrease the value of a code such as HCPCS code G0249 for the provision of test material and equipment for home INR monitoring.

*Response:* Both CPT code 77301 and HCPCS code G0249 were new codes for which we did not have utilization data and which were initially assigned the "all physician" scaling factor. As described above, now that we have the utilization data, the services have been placed in the specialty-specific cost pools based on how the service is billed to Medicare, which have lower scaling factors than the "all physician." This shift has led to the reduced practice expense RVUs for CPT code 77301. If we had placed this code in the radiation oncology cost pool to begin with, it would have had the reduced practice expense payments for the past two years as well. HCPCS code G0249 will actually have increased practice expense RVUs in 2004 due to the effect of the repricing of supplies.

*Comment:* We received one comment that questioned how updated utilization data could have such a huge and direct effect on specific codes. The commenter requested clarification from us on the workings of the utilization data within the practice expense methodology so that the public will understand how utilization data will affect new technologies in the future.

*Response:* As explained above, 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 specialty or specialties performing them. If we do not know the specialty, we have used "all physician" scaling factors. The "all physician" scaling factors could be higher or lower than the specialty-specific scaling factor and produce different RVUs for the code. For instance, CPT code 77301-26 is a PC

service that has no direct cost inputs. Thus, its practice expense RVUs are affected only by the indirect cost scaling factor. To develop the 2003 practice expense RVUs for this code, we adjusted indirect costs allocated to this code by the "all physician" indirect cost scaling factor of 0.57. However, for 2004, we have Medicare utilization data from 2002 for this procedure code. Radiation oncologists and radiologists respectively billed Medicare for 67 percent and 30 percent of the total volume of services provided to Medicare patients in 2002. The weighted average scaling factor for all the specialties that bill Medicare for this procedure code is 0.48. Since we are adjusting indirect costs by 0.48 instead of 0.57, the final practice expense value is lower.

#### *e. Practice Expense Advisory Committee (PEAC)*

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.

#### *1. Recommendations on CPEP Inputs for 2003*

In the December 31, 2002 proposed rule, we responded to the PEAC recommendations for the refinement to the CPEP direct practice expense inputs for over 1200 codes, including refinements to codes from almost every major specialty. In addition, the recommendations included standardized times for office-based clinical staff for services provided during a patient's hospitalization and for discharge day management services, as well as pre-service clinical staff times for 323 neurosurgery procedures. We reviewed and accepted all of the recommendations. We received the following comments on these revisions.

*Comment:* We received comments from specialty societies representing dermatology, dermatologic surgery and Mohs surgery expressing concern regarding the decrease in practice expense RVUs for skin biopsy procedures, CPT codes 11100 and 11101 and the destruction of benign or premalignant lesion services, CPT codes 17000 and 17003. The commenters questioned whether the reductions reflect errors in the validated practice expense inputs used in the practice expense calculations.

*Response:* We have checked the practice expense inputs and found that these match the clinical staff, supply and equipment inputs as recommended by the RUC. The reduction in practice expense RVUs was caused by the