

performed by each specialty. The costs of the original inputs assigned by the Clinical Practice Expert Panels (CPEP) were determined by our contractor, Abt Associates, based primarily on 1994 and 1995 pricing data from supply catalogs. In addition, for many items on the equipment and supply list, the associated costs were based on the recommendations of a CPEP panel member, rather than on actual catalog prices. Subsequent to the CPEP panels, equipment and supply items have also been added to the CPEP data, with the costs of the inputs provided by the relevant specialty society.

We contracted with a consultant to assist in obtaining current pricing information and also to recommend revisions to improve the uniformity and consistency of the CPEP supply database. On the basis of these recommendations, in the August 15, 2003 proposed rule, we proposed updates to the cost information for supplies in the database. In addition, we proposed the following database revisions:

—*Assignment of supply categories.*

We proposed that supplies be assigned to one of 14 categories.

—*Consolidation/standardization of item descriptions.*

We proposed combining items which appeared to be duplicative and modifying descriptions using a key first word when possible for easier identification of items. For example, “mayo stand cover” and “drape, sterile Mayo” have both been changed to “drape, sterile, for Mayo stand.”

—*Standardization of unit descriptions.*

The current CPEP database contains over 72 unit descriptions associated with supplies (for example, item, gram, and cup). To provide consistency and ensure that inputs in the database accurately reflect the quantity of an item used, we proposed to standardize the unit description of items. We also proposed to specifically identify items intended for single use through the use of “uou” (unit of use) following the unit. These changes were reflected in Addendum D of the proposed rule.

There were also items that had not been identified or for which pricing information was not found that were included in Table 1 in the August 15 proposed rule. Items that we proposed to delete from the database were also identified in this table. We requested that commenters, particularly the relevant specialty groups, provide us with the needed pricing information with appropriate documentation. We also stated if we did not obtain verified

pricing information for an item, it would be eliminated from the database.

*Comment:* The RUC expressed appreciation for the enormity of the repricing project and stated that the proposed approach was well organized and comprehensive. The American Association of Orthopedic Surgeons also agreed that the assignment of supply categories would be helpful in future refinement activities. The American College of Physicians, the American College of Surgeons, and the American Urological Association expressed support for our proposal to create a numbering system and to standardize the descriptions of supply items to increase accuracy of use. The American Academy of Dermatology also supported this standardization of proposed “unit of use” as long as its application does not assume that “one size fits all” as some supplies may go from milliliter to liter in usage. The American Society of Cataract and Refractive Surgery and the Outpatient Ophthalmic Surgery Society thanked us for the repricing proposal because this will ensure that we are using the more accurate and up-to-date supply costs, thus reimbursing physicians more fairly. The American College of Radiology recognized the need to update supply and pricing information in the practice expense database and commended us for committing to this extensive project. The American College of Surgeons also agreed that the update of prices for supplies will improve the accuracy of the direct practice expense data. The Society of Nuclear Medicine commended us for committing to this extensive project. The American Urological Association also appreciated this effort and acknowledged it as a huge undertaking.

*Response:* We appreciate the positive feedback and would like to thank all the staff of the specialty societies who worked with our contractor to obtain the most representative prices for all of the supplies in the CPEP input database.

*Comment:* A specialty society representing podiatrists agreed with removal of hallux implant and the broach kit from the list of supplies to be included under practice expense as both are separately billable and the broach kit is also reusable. The commenter did not agree with removal of the sterile ankle tourniquet since this is packaged as a single use item. The comment included pricing information at \$42.87 each (with documentation) for this supply.

*Response:* We will delete the hallux implant and the broach kit from the CPEP supply data. We will retain the ankle tourniquet using the pricing information supplied by the society.

*Comment:* Several commenters expressed concern about the reduction in nonfacility practice expense for the interstitial laser coagulation of the prostate procedure, CPT code 52647. A manufacturer of endo-surgery equipment stated that the main reason for this decrease was the decrease in the price assigned to the laser fiber used in this procedure. We had proposed a price of \$290 for this item, but the commenter submitted documentation that indicated that the laser fiber should be priced at \$850 for CPT code 52647. In addition, the commenter noted that we had proposed in Table 1 to delete the laser fiber because it was reusable; however, this was incorrect as the laser fiber used in this procedure could not be reused and should not be deleted from our supply list.

*Response:* When the laser fiber was repriced, we believed the item included in the supply list for CPT code 52647 was the same as a “laser tip,” which was priced at \$290. We thank the commenters for clarifying the issue. We agree that the laser fiber used in this procedure is a disposable supply that we will retain in our CPEP supply data at the \$850 price documented by the commenter.

*Comment:* Commenters representing cardiac arrhythmia specialists and a remote cardiac monitoring system recommend that we not delete the transtelephonic monitor as a supply even though we are correct that the patient and physician re-use this supply during the course of the pacemaker's life. The specialty society commenter requested that the expense of this supply, which costs \$190, should be spread out over approximately 5 years.

*Response:* The transtelephonic monitor as described would be considered a piece of equipment, rather than a reusable supply. However, unless the equipment costs over \$500, we consider it as an indirect cost and it is not included as a direct input. Therefore, we will delete the item from our list of direct practice expense inputs as proposed.

*Comment:* A specialty society representing chest physicians agreed that the oximetry sensory probe, CPAP nasal pillow and flow sensor are reusable and should be deleted from the list of CPEP supply inputs. The society also agreed that albuterol is separately billable and should also be deleted. Another commenter, representing sleep medicine, agreed that the nasal pillow should be deleted. However, the commenter representing chest physicians and a commenter representing thoracic physicians disagreed with the proposal to delete