

discovered an error in the database. This has now been corrected.

*Comment:* A specialty society representing dermatology commented that the practice expense RVUS for laser treatment of psoriasis procedures, CPT codes 96920–96922, appear overvalued.

*Response:* The practice expense has increased for these codes because we did not have a price for the laser tip used in these procedures until this year. The laser tip is now priced at \$240. We have made adjustments to ensure the practice expense RVUs reflect the correct pricing of supplies as well as the specialty performing the service.

*Comment:* One specialty society that represents gastroenterologists commented that we cut the payment rate for the colonoscopy procedure, CPT 45385, by 10 percent in the nonfacility setting without explanation or justification.

*Response:* The decrease in payment for this code is due to the decreased practice expense inputs now assigned to the service. The PEAC submitted recommendations for the direct practice expense inputs for this service that were based on a presentation made by two other gastroenterological specialty societies, and we have accepted these recommendations because we believe them to be reasonable. The code was included on Addendum C, “Codes for Which We Received PEAC Recommendation on Practice Expense Direct Cost Inputs,” in the proposed rule.

*Comment:* Several commenters representing pediatricians, family physicians and chest physicians stated their concern with the proposed decrease in the practice expense RVUs for immunization services, CPT codes 90471 and 90472, which were removed from the non-physician work pool and priced under the top-down methodology starting in 2003.

*Response:* We will return the two immunization services to the nonphysician work pool. As discussed above, we are increasing the price assigned to the needle stick prevention device that is in the supply list for the immunization codes. However, the practice expense RVUs for these codes would still be less than the current values. As discussed above, the price for the needle stick prevention device is still fluctuating as new manufacturers enter the market. In addition, it is still not clear exactly which device is optimal for the protection of medical staff. Therefore, until these issues are settled, we will price these immunization services in the nonphysician work pool. This will prevent any sharp decrease in payment

for these codes, as well as for payments for the HCPCS G-codes for administration of influenza, hepatitis and pneumococcal vaccines, which are crosswalked to the payment for CPT code 90471.

*Comment:* We received a comment from Venable, a diathermy manufacturer, who voiced concerns about previous decreases in both the work and the practice expense RVUs for the diathermy procedure, CPT code 97024. According to the commenter, the PEAC recommendations we accepted for 2002 included a substantial reduction in clinical labor time, the elimination of supplies, and the undervaluing of the diathermy equipment, including the assignment of inadequate time for equipment use. Citing our current CPEP price of \$3,120 as too low, the commenter noted the cost of the diathermy machines they manufacture range from \$19,000 to \$30,000 and noted the actual time of a typical treatment is 20 minutes, and not 15, as currently listed. A previous comment from the electrophysiology specialty section of the American Physical Therapy Association (APTA) stated that the average cost of diathermy ranges between \$10,000 and \$15,000.

*Response:* We believe the practice expense recommendation we accepted from the PEAC in 2001 for the clinical labor and supplies is appropriate. We would note here that the resultant PEAC recommendation for clinical labor was just one minute less than that proposed by the American Physical Therapy Association at the 2001 PEAC meeting. We continue to support the PEAC’s decision to eliminate the supplies for some of the modality procedures, including diathermy, since these services are typically performed with other therapy procedures where the supply costs are captured. However, we agree with the commenter that the current pricing of the diathermy equipment in our CPEP database appears too low, and we will price the diathermy, on an interim basis, at \$10,000 for the 2004 fee schedule. In addition, we will assign the requested 20 minutes as the typical time the diathermy equipment is in use for each service. We are planning to propose a repricing of all of the equipment included in our database next year and will revisit the pricing of the diathermy equipment at that time.

In response to the commenter’s work RVU concern, next year’s final rule will solicit recommendations of codes to be considered for review under the five-year review of work that is to occur in 2005.

*Comment:* A commenter representing prosthetic urology focused on reductions in payment for several 90-day global prosthetic urology procedures. The commenter contended that these procedures were affected by the adoption of the standard clinical staff times for 90-day global procedures that did not reflect the extra staff time required for patient training during post-procedure visits. In addition, almost half of the prosthetic urology services were established in 2002 and this appeared to have a negative effect on these codes. The commenter strongly recommended that the standard clinical staff times not be applied to the prosthetic urology codes and that we reinstate the “benchmark” clinical staff times.

*Response:* The commenter is correct that the major cause of the decrease in practice expense RVUs for these services is the use of the standard clinical staff time for 90-day global services. We do not have “benchmark” clinical staff times to reinstate for any of these services. Rather, the current staff times are from the original CPEP panel estimates that have not been reviewed by any multi-specialty panel, such as the PEAC. We accepted the PEAC recommendation to apply the standard clinical staff time to all 90-day global services that had not been reviewed by the PEAC as having exceptions to the standard times. All specialties, including urology, had ample opportunity to present any codes for which they believed the standards did not apply; these urology codes were not brought to the PEAC for review. We do not believe we have a sufficient factual basis for changing the clinical staff times for these services in this final rule. However, we would consider any recommendations for revising the pre- and post-service clinical staff times in the future. As to the effect of using the most recent utilization data in calculating the practice expense RVUs for the new prosthetic urology services, please see the discussion on “Utilization Data” earlier in this section.

*Comment:* A specialty society representing emergency medicine, an emergency medicine practice management association and an emergency medicine physician practice management organization all commented that the adjustment made in the November 2, 1998 final rule (63 FR 58821) to use the “all physician” practice expense per hour to calculate two indirect cost pools does not make up for the uncompensated care costs of emergency medicine physicians. The practice management association questioned our previous claim that this