

C. Coding Issues

1. Payment Policy for CPT Tracking Codes

The November 1, 2001 final rule (66 FR 55269) included a discussion of CPT Category III codes (also known as CPT tracking codes) and stated that carriers have discretion for coverage and payment of services described by these CPT tracking codes unless we have made a national coverage determination (NCD). We have received requests to create national payment amounts for some CPT tracking codes even if there has been no NCD. Based on these requests, we proposed to change our policy regarding payment for CPT tracking codes and create national payment policy and determine national payment amounts for CPT tracking codes when there is a significant programmatic need for us to do so. This policy change would not change the contractor's discretion over coverage for the CPT tracking codes, but could establish a payment level to be used if the contractor finds that coverage is warranted. In addition, carriers would not be required to establish a payment amount for a tracking code until they receive a claim for the code.

Comment: Several commenters expressed concerns about this proposal. They believe that establishing a national payment rate for these codes risks premature creation of payment levels of reimbursement and creates an expectation for the future value of the code. The commenters also stated that establishment of a national price could also subvert the RUC process because such pricing could influence subsequent RUC valuation or our acceptance of the RUC's recommendations. Other commenters were supportive of the proposal, with some suggesting that we work with the specialty societies and the RUC in determining appropriate payment rates. One commenter suggested that an alternative to the proposal would be to use the existing refinement panel process because these refinement panels are multispecialty and feature the relevant specialty expertise. One commenter also requested we establish RVUs for specific tracking codes in the final rule.

Response: We understand the reservations and concerns of the commenters. As we indicated in the proposed rule, we would determine national payment amounts for CPT tracking codes *only* when there is a significant programmatic need for us to do so. If there is a need to establish payment amounts for a tracking code, we would appreciate the assistance of the relevant specialty societies and the

RUC and such pricing would be subject to public comment. However, in some instances, interim values might need to be established if timing does not permit us to obtain prior input from the medical community.

Final Decision

We will finalize our proposal to create national payment policies and determine national payment amounts for CPT tracking codes when there is a significant programmatic need for us to do so. We note that, as discussed in the August 15, 2003 proposed rule, this policy change would not change the contractor's discretion over coverage for CPT tracking codes, but would establish a payment level if the contractor finds that coverage is warranted.

2. Excision of Benign and Malignant Lesions

The definitions for excision of benign lesions (CPT codes 11400 through 11446 inclusive) and excision of malignant lesions (CPT codes 11600 through 11646 inclusive) were substantively changed for 2003. These codes are now reported based on the excised diameter (actual skin removed) rather than on the size of the lesion. Based on these changes to the code descriptors, we proposed to make the work RVUs the same for removal of all skin lesions with the same excised diameters that are from the same area of the body, whether the lesions are benign or malignant. For example, the work RVUs for the removal of benign skin lesions from the trunk, arms or legs with excised diameter 1.1–2.0 cm, CPT code 11402, would be the same as the work RVUs for CPT code 11602, which is the removal of *malignant* skin lesions from trunk, arms or legs with excised diameter of 1.1–2.0 cm.

Comment: The specialty society representing dermatology objected to this proposal and contended that the excision of malignant lesions generally goes deeper and is more time-consuming than the excision of benign lesions and that malignant lesion excision also requires greater skill and embodies greater risk. The society stated that this proposal ignores a multi-specialty effort by a CPT Integumentary Workgroup, the CPT Editorial Panel and the RUC to revise the code descriptors and to assign work RVUs to these services. This view was supported by a joint comment from the heads of several surgical specialties. The RUC also urged us to delay finalizing this proposal until the RUC has the opportunity to provide further recommendations related to these services. In addition, the specialty societies representing podiatry, general

surgery, colon and rectal surgery, osteopathy, ophthalmology, plastic surgery, otolaryngology as well as the AMA, the Mayo Foundation and individual physicians also urged us to withdraw this proposal. Medical Group Management Association requested the policy rationale for equating the work RVUs for the benign and malignant code pairs. The specialty society representing family physicians agreed with and supported our position that there is no difference in physician work involved in excising a benign or malignant lesion. However, the commenter did not support our proposal to implement such RVU changes unilaterally and stated that we should utilize the CPT and RUC process.

Response and Final Decision: We still believe that the physician work for these services is sufficiently similar not to warrant differences in the work RVUs. However, we will maintain the 2003 work RVUs as interim values for 2004 to allow opportunity for the specialty to resurvey these services. Note: That due to the adjustments to work RVUs to match the MEI weights, the work RVUs in Addendum B may differ from the values in 2003.

3. Create G Codes for Monitoring Heart Rhythms

As explained in the August 15, 2003 proposed rule, technological advances have made cardiac telemetry equipment, typically used in hospitals, available in the home setting. Coverage of this technology is currently at the discretion of the local Medicare contractors because there is no national coverage determination for this service. We proposed to establish new HCPCS codes to specifically describe this service along with proposed RVUs and PE inputs for payment as follows:

GXXX1—Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; includes recording, monitoring, receipt of transmissions, analysis, and physician review and interpretation. (global)

We proposed 0.52 physician work RVUs and 0.24 malpractice RVUs for this service and proposed crosswalking the practice expense inputs from CPT Code 93268 *Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission physician review and interpretation.*