

diagnostic colonoscopy. We have established RVUs for an incomplete diagnostic colonoscopy (CPT code 45378–53). However, an incomplete screening colonoscopy (HCPCS G0105 with modifier ‘53’ or HCPCS G0121 with modifier ‘53’) is currently carrier priced. To make payment for screening colonoscopy consistent with payment for a diagnostic colonoscopy, effective January 1, 2004, Medicare will make payment for an incomplete screening colonoscopy, HCPCS G0105 with modifier ‘53’ and HCPCS G0121 with modifier ‘53’, at the same rate as an incomplete diagnostic colonoscopy (CPT 45378–53). The Medicare carriers will no longer manually price the practitioner payment for an incomplete screening colonoscopy.

H. Publication Issues

Comment: Several commenters noted that section 1871 of the Act requires a 60-day public comment period. Such period traditionally starts with the date the proposed rule is published in the **Federal Register**. However, for the Physician Fee Schedule Proposed rule, CMS began the start of the 60-day comment period on August 8, the date the proposal was put on display at the **Federal Register**, rather than August 15, the date the proposal was published in the **Federal Register**. The commenters request that CMS revert to the traditional start of the comment period, that is, the date of publication in the **Federal Register**. One commenter suggested that CMS should accept electronically submitted comments when the comment period begins earlier than the publication date.

In addition, several commenters urged CMS to resolve the process issues associated with publishing the proposed and final rule. They indicated that the delayed publication of the proposed rule, combined with missing information from addendums and impact tables, makes review and analysis problematic. The commenters also expressed concern that CMS has insufficient time to evaluate public comments and this is contrary to the spirit of the Administrative Procedures Act.

Response: CMS is keenly aware of the tight time frame between publication of the proposed and final rules. We make every effort to respond to requests from physician specialty groups and providers to include items in the proposed rule that affect payment levels, such as assigning RVUs to new CPT codes and revising RVUs for existing codes. It is difficult to both address numerous concerns and publish the proposed rule in a timely fashion.

We will continue to make every effort to publish the proposed rule as early as possible. However, despite the short time frame for issuing the final rule, we take the review and analysis of comments very seriously. CMS devotes the necessary staff resources to ensure that every comment is properly considered.

Furthermore, the statute does not provide that the comment period commences with publication in the **Federal Register**. Section 1871(b)(1) of the Act states that before issuing a regulation in final form, “the Secretary shall provide for notice of the proposed regulation in the **Federal Register** and a period of not less than 60 days for public comment thereon.” While the proposed rule did not actually appear in the **Federal Register** until August 15, 2003, it was filed and went on public display at the **Federal Register** several days earlier on August 8, 2003. Accordingly, the contents of the proposed rule were, in fact, publicly available for the full 60-day comment period.

IV. Refinement of Relative Value Units for Calendar Year 2004 and Response to Public Comments on Interim Relative Value Units for 2003

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

Section IV.B of this final rule describes the methodology used to review the comments received on the RVUs for physician work and the process used to establish RVUs for new and revised CPT codes. Changes to codes on the physician fee schedule reflected in Addendum B are effective for services furnished beginning January 1, 2004. The tables and discussions in this section concerning the work RVUs do not reflect the effect of the adjustment to work RVUs to match the MEI weights as discussed in section VI. The referenced work RVUs may differ from the work RVUs in Addenda B and C that reflect this adjustment.

B. Process for Establishing Work Relative Value Units for the 2004 Physician Fee Schedule

Our December 31, 2002 final rule (67 FR 79966) announced the final work RVUs for Medicare payment for existing procedure codes under the physician fee schedule and interim RVUs for new and revised codes. The RVUs contained in the final rule applied to physician services furnished beginning March 1, 2003. We announced that we considered the RVUs for the interim codes to be subject to public comment under the

annual refinement process. In this section, we summarize the refinements to the interim work RVUs published in the December 2002 final rule and our establishment of the work RVUs for new and revised codes for the 2004 physician fee schedule.

C. Work Relative Value Unit Refinements of Interim Relative Value Units

1. Methodology (Includes Table titled “Work Relative Value Unit Refinements of the 2003 Interim and Related Relative Value Units”)

Although the RVUs in the December 2002 final rule were used to calculate 2003 payment amounts, we considered the RVUs for the new or revised codes to be interim. We accepted comments for a period of 60 days. We received substantive comments from many individual physicians and several specialty societies on approximately 10 CPT codes with interim work RVUs. Only comments on codes listed in Addendum C of the December 2002 final rule were considered.

To evaluate these comments we used a process similar to the process used in 1997. (See the October 31, 1997 final rule (62 FR 59084) for the discussion of refinement of CPT codes with interim work RVUs.) We convened a multispecialty panel of physicians to assist us in the review of the comments. The comments that we did not submit to panel review are discussed at the end of this section, as well as those that were reviewed by the panel. We invited representatives from the organization from which we received substantive comments to attend a panel for discussion of the code on which they had commented. The panel was moderated by our medical staff, and consisted of the following voting members:

- One or two clinicians representing the commenting organization.
- One primary care clinician nominated by the American College of Physicians/American Society of Internal Medicine.
- Four carrier medical directors.
- Four clinicians with practices in related specialties, who were expected to have knowledge of the service under review.

The panel discussed the work involved in the procedure under review in comparison to the work associated with other services under the physician fee schedule. We assembled a set of 300 reference services and asked the panel members to compare the clinical aspects of the work of the service a commenter believed was incorrectly valued to one