

wave therapy; involving musculoskeletal system, which is an emerging technology code and also created two new HCPCS codes (G0279 and G0280) with payments based on our valuation of this CPT code. In the August 15, 2003 proposed rule we also requested additional information on these services.

Comment: Commenters on the December 2002 rule indicated that assignment of RVUs for CPT code 0020T is contrary to national policy established in the November 1, 2001 (66 FR 55269) final rule. They also indicated that the assumptions used to assign RVUs to these services were incorrect and undervalued these services.

Response: In a correction notice published May 30, 2003 (68 FR 32400) we indicated that we had incorrectly assigned RVUs to these services and they would be carrier priced.

Comment: Commenters on the December 2002 rule expressed concern that the G codes were not reflective of the changes in technology and FDA approval of ESWT. Commenters also disagreed with our categorization and portrayal of CPT 0020T as a procedure similar to other physical therapy modalities. Commenters urged us to correct and clarify that CPT 0020T is not physical therapy service but a physician procedure and thus should be removed from the list of codes identifying certain designated health services.

Response: We understand that this is a changing technology and believe the current descriptors accommodate these changes. We are removing CPT 0020T from the list of designated health services in Addendum F since we agree that, at this time, this service is predominantly performed by medical specialties such as orthopedists and podiatrists.

Comment: Commenters on the August 15, 2003 proposed rule urged us to continue to have these services priced by the carrier and expressed concern that our request for additional information indicated we would be establishing national payment amounts for these services. In addition, several physicians provided information on how this service is used in their offices, including cost information as well as a description of the procedure. Some commenters recommended that separate G codes be established to differentiate between the high and low energy levels that are currently used, as this impacts the treatment protocols as well as the resources used in these procedures.

Response: The purpose for soliciting information in the proposed rule was to gain a better understanding of the use of

the various systems as well as the resources involved with this procedure. We appreciate the information the commenters provided and will continue to review this issue to determine if coding changes are warranted. We are retaining the current codes, G0279, G0280 and CPT code 0020T under the fee schedule and these will continue to be carrier priced. We believe this will enable the carriers to make appropriate payment for these services based on resources used. In addition, as previously discussed, we are removing CPT code 0020T from the list of designated health services in Addendum F.

G0288 Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery.

We created this code, which is a technical component code, to assure accurate reporting of this service by independent diagnostic testing facilities (IDTFs) that perform this service. This service includes receipt of a Computed Tomographic Angiogram (CTA), post-CTA processing using specialized software, and burning the 3D model onto a CD and returning it to the operating surgeon. This 3D only model is used to assist vascular surgeons in planning for, or monitoring the results of, endovascular aneurysm repair. The service is a technical service provided under the general supervision of a physician according to the supervision requirements for IDTFs.

Comment: Commenters requested clarification on whether this code could be used for the treatment planning both prior to surgery as well as for post-surgical monitoring. They also indicated that it should be expanded to include the use of enhanced computed tomography scans or magnetic resonance images and not just those generated by CTA. In addition, one commenter suggested that CMS ensure that this HCPCS code is used only for those technologies that meet the following criteria: (1) The ability to perform precise modeling of multiple clinically-relevant objects; (2) the ability to generate specific measurements essential for surgical planning and follow-up; (3) built-in quality control and self-validation capabilities; (4) FDA marketing clearance for use in surgical planning and follow-up treatment; and (5) conformance to standards adopted by the International Standards of Organization (ISO).

Commenters also suggested that the payment for this code be revised so that it is more in line with the payment for these services when administered in the outpatient setting.

Response: We agree that this service can be used for treatment planning prior to surgery as well as for post-surgical monitoring and have revised the code descriptor to clarify this point. The descriptor for this code is revised as follows:

G0288 Reconstruction, computed tomographic angiography of aorta for preoperative planning and evaluation post vascular surgery.

However, we are not expanding this service to include the use of enhanced computed tomography scans or magnetic resonance, as we have not been presented with information to support its use with these other data sources. We assume that physicians providing this service will abide by the FDA labeling requirements for the specific equipment used. Payment for services under the outpatient prospective payment system is based on a different methodology than services paid under the physician fee schedule. As required by section 1848 of the Act, payment under the physician fee schedule is based on national relative value units based on resources used in furnishing the service. We believe the RVUs established for this service are reflective of the resources used, and therefore do not believe this should be carrier priced.

G0289 Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee.

We created this add-on code to permit appropriate reporting of arthroscopic procedures performed in different compartments of the same knee during the same operative session. We stated that this code should be reported only when the physician spends at least 15 minutes in the additional compartment performing the procedure. It should not be reported if the reason for performing the procedure is due to a problem caused by the arthroscopic procedure itself. We noted that this code is to be used when a procedure is performed in the lateral, medial, or patellar compartments in addition to the main procedure. We assigned a work RVU of 1.48 to this code RVUs based on a comparison to CPT codes 29874, 29877 and 29870, the base procedure for this family of codes.

Comment: Commenters appreciated our efforts to address the issue of reimbursement for this procedure. However, they expressed concern about the specific reference to a 15 minute time requirement. The commenters believed that this was inappropriate because using time in this manner