Neltner Billing & Consulting Services, Inc.

The 85095/85102 Brief

The need to correct inappropriate coding edits for CPT codes 85095 (bone marrow aspiration) and 85102 (bone marrow biopsy)

June 2001

BMBBRIEF.DOC

COVER LETTER

Dear Medicare:

Enclosed are 150 claims for CPT codes 85095 (bone marrow aspiration) and 85102 (bone marrow biopsy) that we are submitting for your review. All of the enclosed claims were submitted prior to April 1, 2001.

We wish you to address what we deem is an inappropriate policy adopted by Medicare of Indiana based on the CCI guidelines..[1] The Oncology Reference Manual mentions nothing about bundling these two procedures. Nor could we find any other reference except in an article in the Medicare Part B Bulletin titled "Proper Coding of 85095 and 85102."[2] This article mentions that providers "should determine the amount of overpayment they have received and voluntarily return it to the carrier." This, we feel, is not an appropriate determination of overpayment.

We are submitting this brief to Dr. Niles Rosen, Medical Director of the National Correct Coding Initiative, to challenge the inappropriate bundling of these two separate medically necessary and appropriate procedures. We offer evidence from various sources to support our claim. As you know, there are many precedents that allow physicians to be reimbursed for different procedures performed on the same date of service for the same patient. The bundling of CPT codes 85095 and 85102 should not apply for the following reasons:

1). The bone marrow aspiration, CPT code 85095, is a separately identifiable procedure from the bone marrow biopsy, CPT code 85102.

2). It is inappropriate to deny a medically necessary procedure without requesting comments or submitting this change through the appropriate channels, including the AMA, etc. We can find no evidence of any comment period or regulatory citation to allow this change.

3). The UCR historical data used to create the relative value units (RVU) is too low for each procedure. The practice expense allowance currently is not adequate to cover the actual practice expenses for providing this service:

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[1] National Correct Coding Guide (CCI-Version 7.1), April 01, Pathology-10 (copy enclosed – see Appendix A)

[2] Medicare Part B Bulletin, December, 2000, 00-10, page 92 (copy enclosed – see Appendix A)

CPT Code	PE RVU	Conv Fact	Allowable	PE RVU*	Mod All*	Diff
85095	2.51	$36.6137	$91.90	4.29	157.07	$65.17
85102	2.64	$36.6137	$96.66	4.41	$161.47	$64.81

*This is the fully implemented PE RVU which will be in effect in year 2002.[3] The modified allowable is the amount using the 2000 conversion factor times the fully implemented RVU.

The difference between the allowables using the two RVU values is about 70%. This means that Medicare already recognizes they are underpaying the service. Additionally, there is no proportionate increase in the RVUs for the bone marrow biopsy (85102) to incorporate the bundling of the bone marrow aspiration into the procedure.

Addendum B of the Federal Register, which lists CPT codes and their RVU values, includes a status indicator that "shows whether the CPT/HCPCS code is in the physician fee schedule and whether it is separately payable if the service is covered…. A= Active code. These codes are separately payable under the fee schedule if covered." Both CPT code 85095 and CPT code 85102 have "A" status indicators.[4]

Please send us a written verification for each claim with an assigned reference number that indicates these claims are in review and the anticipated time these claims will remain in review. Please also send a written copy of the regulation that states the change in policy regarding these two procedures.

If you have any questions I am available at (859) 653-3073 and Mneltner@aol.com.

Sincerely,

Martin E. Neltner
President & Senior Consultant

[3] See Appendix C.

[4] Federal Register, November 1, 2000.

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REGULATORY CITATIONS

MEDICARE COVERAGE ISSUES MANUAL

Function of the Medicare Coverage Issues Manual .--The Coverage Issues Manual sets forth whether specific medical items, services, treatment procedures or technologies can be paid for under Medicare. National coverage decisions have been made on the items addressed in this manual. All decisions that items, services, etc. are not covered are based on §l862(a)(1) of the Social Security Act (the "not reasonable and necessary" exclusion) unless otherwise specifically noted. Where another statutory authority for denial is indicated, that is the sole authority for denial. Where an item, service, etc. is stated to be covered, but such coverage is explicitly limited to specified indications or specified circumstances, all limitations on coverage of the items or services because they do not meet those specified indications or circumstances are based on §l862(a)(1) of the Act. Where coverage of an item or service is provided for specified indications or circumstances but is not explicitly excluded for others, or where the item or service is not mentioned at all in this Manual, the Intermediary Manual, or the Carriers Manual, it is up to the Medicare contractor to make the coverage decision, in consultation with its medical staff, and with the Health Care Financing Administration (HCFA), when appropriate, based on the law, regulations, rulings and general program instructions.[5]

SSA SECTION 1862

SEC. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services--

(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

SSA SECTION 1879

Section 1879 of the Social Security permits Medicare to pay providers on assigned claims for services otherwise not covered if neither the beneficiary nor the physician knew, or could reasonably be expected to know, that the services were not covered. Section 1879 affects services disallowed as not medically necessary or not reasonable for: (a) the diagnosis or treatment of illness or injury, and (b) services performed to improve the functioning of a malformed body member.

[5] Medicare Coverage Issues Manual, HCFA Pub. 6, Forward

SSA SECTION 1870

Section 1870 of the Act permits Medicare carriers to not recover inappropriate payments with respect to an individual deemed without fault for having caused the overpayment. For the "without fault" provision to apply, the individual must have complied with all pertinent regulations and instructional materials. These include CPT code definitions, and Medicare Bulletins. The individual is expected to have had a reasonable basis for assuming that payments received were correct or, if there was reason to question the payment, to promptly bring such a question to the carrier's attention. In addition, the individual is expected to have made full and accurate disclosure of material facts.

COMMENTS

Each of these citations uses broad terms such as "reasonable and necessary." Each clearly cites that "it is up to the Medicare contractor to make the coverage decision in consultation with its medical staff, and with the Health Care Financing Administration when appropriate based on the law, regulations, rulings, and general program instructions."

We claim the CCI and Medicare contractor inappropriately bundled the two procedures, bone marrow biopsy (CPT code 85102) and bone marrow aspiration (CPT code 85095). We feel that CCI and Medicare should consider the following:

- There is a long-standing history of payments by Medicare and other payers for these two procedures.

- The two procedures are, in fact, distinct, separate procedures, even when performed through the same incision. Each can be performed independently of the other. Reference the excerpts from the *CPT Assistant* (published by the American Medical Association) included in Appendix B.

- The reimbursement for both procedures is already too low to cover expenses incurred by the physician. The increase in RVUs, which will increase reimbursement by 70%, for the procedures due to the resource-based practice expense component will not be fully implemented until 2002. Denials for services which are already paid below cost only exacerbates the problem.

Unfortunately, denials of this nature force physicians to reconsider where to provide the service to their patients. Many physicians are choosing to treat the patient in the hospital outpatient setting because the current reimbursement for the procedures doesn't even cover their overhead expenses to provide the service. This is inconvenient for Medicare patients, and more costly to the Medicare program.

Enclosed (Appendix B) are various articles from the *CPT Assistant* that clarify the correct coding of bone marrow procedures. We are aware that HCFA does not always follow the AMA coding guidelines. However, we believe the information will show that the bundling of these two services is inappropriate. If bundling is to be appropriate, the RVU

for the bone marrow biopsy (85102) should be increased. This has not occurred exclusive of the practice expense increments.

We understand the intent of the CCI is to ensure that Medicare pays appropriately for services and procedures. It may appear that these two procedures should be bundled because the needle is only inserted once. In reality, the procedure does require two separate insertions through the tube where the needle has been inserted to aspirate the marrow and withdraw a biopsy. Both procedures need to be performed. Does Medicare want patients to make a separate visit to the office for each procedure?

We ask both the CCI and Medicare to reconsider this issue. We hope this information provides insight into the necessity of paying for both procedures.

APPENDIX A

EXCERPT FROM NATIONAL CORRECT CODING GUIDE, APRIL 2001

Comprehensive Code	Component Code
85013	85021✓ 85022✓ 85023✓ 85024✓ 85025✓ 85027✓ 85031✓
85014	85013✓ 85021✓ 85023✓ 85024✓ 85027✓ 85031✓
85018	85008✓ 85021✓ 85023✓ 85024✓ 85027✓ 85031✓
85021	85023✓ 85024✓ 85025✓ 85027✓ 85031✓
85022	85007◆ 85014✓ 85018✓ 85021✓ 85023✓ 85024✓ 85025✓ 85027✓ 85031✓ 85585◆
85023	85007◆ 85585◆ 85590◆ 85595◆
85024	85023✓ 85585◆ 85590◆ 85595◆
85025	85014▼ 85018▼ 85023✓ 85024✓ 85585◆ 85590◆ 85595◆
85027	85023✓ 85024✓ 85025✓ 85585◆ 85590◆ 85595◆
85031	85023✓ 85024✓ 85025✓ 85027✓ 85585◆
85041	85021✓ 85022✓ 85023✓ 85024✓ 85025✓ 85027✓ 85031✓
85048	85021✓ 85022✓ 85023✓ 85024✓ 85025✓ 85027✓ 85031✓
85095	80500❄ 80502❄
85102	20220◆ 80500❄ 80502❄ 85095❄
85130	80500❄ 80502❄
85170	80500❄ 80502❄
85175	80500❄ 80502❄
85210	80500❄ 80502❄
85220	80500❄ 80502❄
85230	80500❄ 80502❄
85240	80500❄ 80502❄
85244	80500❄ 80502❄
85245	80500❄ 80502❄
85246	80500❄ 80502❄
85247	80500❄ 80502❄
85250	80500❄ 80502❄
85260	80500❄ 80502❄
85270	80500❄ 80502❄
85280	80500❄ 80502❄
85290	80500❄ 80502❄
85291	80500❄ 80502❄
85292	80500❄ 80502❄
85293	80500❄ 80502❄
85300	80500❄ 80502❄
85301	80500❄ 80502❄
85302	80500❄ 80502❄
85303	80500❄ 80502❄
85305	80500❄ 80502❄
85306	80500❄ 80502❄
85335	80500❄ 80502❄
85337	80500❄ 80502❄
85345	80500❄ 80502❄
85347	80500❄ 80502❄ 85345✓ 85348✓
85348	80500❄ 80502❄ 85345✓
85360	80500❄ 80502❄
85362	80500❄ 80502❄
85366	80500❄ 80502❄
85370	80500❄ 80502❄
85378	80500❄ 80502❄
85379	80500❄ 80502❄
85384	80500❄ 80502❄
85385	80500❄ 80502❄

Sanctioned and Reinstated Providers cont'd

Reason for Exclusion

1128 (a)(1)	Convicted of a crime involving the Medicare, Medicaid, maternal and child health services block grant or block grants to states for social services programs
1128 (a)(2)	Convicted of a crime related to patient abuse or neglect
1128 (a)(3)	Felony conviction relating to health care fraud
1128 (a)(4)	Felony conviction relating to controlled substance violations
1128 (b)(3)	Conviction relating to controlled substances
1128 (b)(4)	License revocation or suspension
1128 (b)(5)	Suspension or exclusion under a Federal or State health care program
1128 (b)(6)	Excessive claims or furnishing of unnecessary or substandard items or services
1128 (b)(7)	Fraud, kickbacks and other prohibited activities
1128 (b)(8)	Entities owned or controlled by a sanctioned individual
1128 (b)(14)	Default on health education loan or scholarship obligations

MEDICARE FRAUD ALERT

Activity:

Physicians are billing for services not rendered, and for physical therapy services that were not personally rendered by the attending physician or under appropriate supervision. The claims submitted to Medicare imply that physicians supervise the physical therapy. The claims are submitted by utilizing the physician's Medicare provider number. However, the medical records reveal that Nurse Practitioners supervise the physical therapy, not the physicians. "Incident to" can only be billed by the individual, which performs the supervision.

The targeted beneficiaries being treated live in high rises or senior citizen homes, and are transported by vans provided by the subjects of this Alert.

PROPER CODING OF 85095 AND 85102

The carrier's data analysis has identified improper coding of 85095 (bone marrow; aspiration only) and 85102 (bone marrow biopsy, needle or trocar).

Normally, both a bone marrow biopsy and aspiration are performed through the same incision. In these situations, only 85102 should be reported. If the bone marrow biopsy and bone marrow aspiration must be performed through separate incisions because it is not medically reasonable to perform them both through the same incision, both 85102 and 85095 should be reported. This latter situation is very uncommonly encountered in practice.

The National Correct Coding Initiative includes an edit bundling 85095 into 85102. If the two procedures must be performed through separate incisions, both codes may be reported appending the –59 modifier to either code. This effective date of this edit was October 1, 1997.

Our data analysis indicates that some providers are inappropriately appending the –59 modifier when both procedures are performed through the same incision. We advise providers who bill both these codes to review their claims since October 1, 1997 to determine whether they were billed properly. Providers who have improperly appended the –59 modifier should determine the amount of overpayment they have received and voluntarily return it to the carrier.

APPENDIX B

HEMATOLOGY AND COAGULATION, 85095, 85102 (Q&A)
Source: CPT Assistant Oct 98:11

(Q&A); Can my physician report codes 85095, Bone marrow; aspiration only, and 85102, Bone marrow biopsy, needle or trocar? He is under the impression that he cannot bill codes from this section because he is not a pathologist.

Both codes (85102 and 85095) are located in the pathology and laboratory section of CPT even though they represent obtaining the biopsy and aspiration. Since CPT is a nomenclature rather than a strict classification system, there may be some procedures that appear in sections other than in those where they ordinarily might be classified. From a historical perspective, CPT has always placed procedures in general sections according to where physicians will most conveniently find them.

It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group. Any procedure or service in any section of this book may be used to designate the services rendered.

Therefore, if your physician performed the services described by codes 85095 and 85102, then both services may be separately reported, regardless of the specialty of your physician.

WHAT IS THE INTENT OF CODES 85102 AND 85095?
Can both be reported on the same date of service?

From a CPT coding perspective, codes 85102 and 85095 represent different procedures. CPT code 85102 describes a biopsy of the bone marrow using a needle or trocar when a core of bone marrow is withdrawn with the needle. CPT code 85095 describes an aspiration of the bone marrow when tissue is aspirated from the bone marrow into a needle attached to a syringe. Therefore it may be appropriate to report codes 85102 and 85095 as both of these procedures involve separate techniques to obtain different specimens.

BONE MARROW BIOPSY, BONE MARROW ASPIRATION, & BONE BIOPSY
Source: CPT Assistant Jul 98 page 4

We have received numerous requests to explain the differences between the bone marrow biopsy code, bone marrow aspiration codes, and bone biopsy codes. An explanation of the techniques used in all three sets of codes as well as examples of when each technique is used may help to differentiate these procedures. A glossary of terms related to this article is also included.

The pathologic examination of the bone marrow obtained by biopsy is a widely used

method to detect diseases which express themselves in the alteration of the usual cell types normally present within the bone marrow. The bone marrow biopsy is fixed, decalcified, and processed in a histology laboratory as any other surgical specimen. It is an invaluable tool for the appraisal of overall cellularity, the presence and relative quantification of abnormal cells such as the cells of a malignant lymphoma or leukemia, the relative abundance of cells, which are part of the normal marrow, such as megakaryocytes, and the presence of abnormal cells such as seen in Nieman-Pick disease. It also is used for the detection of tumor metastases to the marrow, and the presence of myelofibrosis.

CPT code 85102 describes the technique of removal of a small piece(s) of the cancerous bone via a needle (such as Jamshidi) or trocar

Generally, the ileum is biopsied at the superior iliac spine. Other sites such as the sternum, the spinous processes, or in patients under 4 years of age, the tibia, may be used.

First, a wide area around the puncture site is cleaned with an antiseptic solution. After anesthetizing the skin and periosteum of the biopsy site, a 3 mm incision is made in the skin. Then the needle, with obturator in place, is inserted into the skin incision and through the subcutaneous tissue to the cortex of the bone. The cortex is penetrated and the obturator is removed. The needle is slowly advanced with twisting motions (clockwise, counter-clockwise).

After sufficient penetration of the bone, the needle is rotated several times and withdrawn several millimeters, then reinserted to the original depth at a slightly different angle. The needle is again rotated several times in order to free the specimens from attachments in the marrow cavity. Next the needle is slowly withdrawn using the same twisting motion employed during insertion. The core of marrow inside the needle is removed as the biopsy.

The interpretation of the bone marrow biopsy is included in code 88305, as a type of surgical pathology specimen. If both staining and interpretation are performed, the proper way to report this code is by the use of the code 88305 without a modifier, as a global service code. If only the professional interpretations is performed, then code 88305-26 is used.

A bone marrow aspiration may be performed independent of a bone marrow biopsy, or may immediately follow a biopsy. For example, when a physician is following a known case of leukemia, then only the nature of the cellular population needs to be evaluated. A bone marrow aspiration is a sufficient procedure when the relationship of the infiltrating cells to the bone marrow (ie, its cellularity) is not necessary for appropriate patient management.

CPT code 85095 describes the procedure of marrow aspiration.

The site chosen for the aspiration depends on the age of the patient. Most marrow aspirates from both children and adults are now obtained through the iliac crest at the posterior superior iliac spine. In adults, the sternum and the anterior iliac crest may also

be utilized. In children less than 1-year-old, the anteromedial surface of the tibia is sometimes used, while in older children, the iliac crests or the vertebral spines may be aspirated.

After anesthetizing the skin and periosteum, the marrow needle is inserted through the skin and subcutaneous tissue to the bone with a slight twisting motion. The cortex of the bone is penetrated. The stylet of the needle is then removed and the hub of the needle is attached to a 10-20 ml syringe, and approximately 0.2 to 0.5 ml of fluid is aspirated. The needle is removed from the bone immediately after the marrow has been aspirated (ie, the aspiration does not produce intact tissue, but only the cellular contents of the needle). Pressure is applied at the site of the aspiration to prevent bleeding.

CPT code 85097 is used to report the interpretation of a smear resulting from the bone marrow aspiration procedure.

The smears are stained in a hematology laboratory or a physician's office. Whether a differential cell count is performed or whether the findings are reported in a more descriptive fashion, the same code applies. If a cell block is also prepared from the aspirated material, and the clot is processed as a cell block in the histology laboratory, the additional code 88305 is also reported.

Both codes 85095 and 85097 should be reported if the same physician both aspirates and interprets and smears.

If only physician services are performed, then codes 85095 and 85097 are reported with the modifier -26; if technical services (such as staining) are also performed by a physician or the laboratory, then the codes should be used without a CPT modifier.

The deleted code 85101 services are now reported as 85095 as a global service. If only aspiration is performed, the service is appropriately coded as 85095-26.

Other codes.

When a patient has a lesion or disease of the bone, rather than of the bone marrow, a biopsy specimen of the bone is taken to establish the diagnosis. In general, the clinical presentation will be a patient with a specific lesion of bone seen by x-ray or imaging studies. This may be a primary bone tumor, a metastasis, or may represent a metabolic derangement of bone, such as seen in Paget's disease or in the brown tumor of hyperparathyroidism. For example, a lytic lesion of bone may be biopsied to establish the nature of the underlying process, whether malignant or metabolic.

The procedure involves the removal of bone, including one or both cortical plates, and of representative material of the cancellous bone, if appropriate. Since the purpose of the biopsy is to establish a diagnosis for a bone lesion, the presence of bone marrow in the biopsy specimen is only incidental.

In certain situations, percutaneous needle biopsy (of bone) allows for histologic diagnosis with lower cost and morbidity than open biopsy does. This is particularly true for tumors

of the spinal column. A percutaneous needle biopsy can allow metastasis to be excluded or confirmed. If surgical intervention is contemplated, a needle is rarely performed.

Codes 20220, 20225 describe the removal of a specimen of bone (not of bone marrow) by using a trocar or needle.

If a primary bone tumor is suspected, an open biopsy, rather than a needle biopsy, is generally performed.

Codes 20240 20240 20245 20250 - 20251 describe open bone biopsies.

A surgical incision is made as directly as possible down to the bone lesion. The surgeon generally goes through muscle rather than dissecting around muscle planes, in order to minimize dissemination of the lesion. Care is also taken to provide the excellent hemostasis to minimize the dissemination of tumor cells around the biopsy site.

In Summary

1. CPT code 85102 describes a biopsy of the bone marrow using a needle or trocar when a core of bone marrow is withdrawn with the needle.

2. CPT code 85095 describes an aspiration of the bone marrow when tissue is aspirated from the bone marrow into a needle attached to a syringe.

3. CPT codes 20220, 20225 describe the removal of a portion of bone (not bone marrow) via a needle or trocar.

4. CPT code 88305 describes the examination of the bone marrow cell block prepared from the smear.

5. CPT code 88305 describes the examination of the bone marrow biopsy.

6. CPT code 88307 describes the examination of the bone biopsy.

7. CPT code 88311 describes the decalcification of bone marrow biopsy or bone biopsy.

8. CPT codes 20240 20240 20245 20250 - 20251 describe bone (not bone marrow) biopsies performed through an open incision.

9. CPT code 85097 describes the examination of the bone marrow smear.

   Other CPT codes may be reported as needed to establish the diagnosis (eg, special or immunohistochemical techniques).

Glossary of Related Terms

The definitions provided in this glossary relate only to this article. There may be other

definitions/interpretations of these terms related to medical practice or other specialties.

Anterior: The front surface of; in front of.

Biopsy: The removal and examination (usually microscopic) of tissue from the living body, performed to establish a precise diagnosis.

Bone Marrow: The highly vascular, soft, pulpy network of reticular tissue that fills the cavities of most cells.

Cellularity: The state of a tissue or other mass as regards to the number of constituent cells.

Clot (Bone Marrow): A semisolid mass derived from bone marrow aspiration and processed in the histology laboratory for pathologic examination.

Cortex: The outer layer of an organ or other body structure, as distinguished from the internal substance.

Disseminated: Scattered distributed over a considerable area.

Follicle: A small secreting sac.

Hematology: The science dealing with the formation, composition, functions, and diseases of the blood and the morphology of the blood forming organs.

Hemastasis: Arrest of bleeding.

Histology: Microscopic study of the structure of cells and tissues. Humerus: The bone of the upper arm, between the elbow and the shoulder joint.

Ilium (Iliac): The large, flaring, lateral and uppermost of the three bones that compose the innominate (hip) bone.

Leukemia: Progressive, malignant disease of the blood-forming organs.

Lymphoma: Any neoplastic disorder of the lymphoid tissue.

Megakaryocyte: Giant multi-nucleated cells in the bone marrow from which the mature blood platelets originate.

Metastasis: The transference of bacteria or body cells, especially cancer cells, from the original site to another part of the body, usually by blood in lymph, and resulting in development of a similar lesion at the new site.

Morbidity: The state of being sick or diseased.

Morphology: The science that deals with the form and structure of living things, regarded as a whole, and apart from their function.

Myelofibrosis: Excessive growth of bone marrow.

Neoplasm: Any abnormal, progressive, uncontrolled growth of cells or tissues that serve no useful purpose; a tumor.

Nieman-Pick Disease: A hereditary disease of lipid metabolism, occurring chiefly in female Jewish infants.

Obturator: Any natural or artificial thing that closes an opening.

Paget's Disease: A chronic disease of the bone that resembles arthritis.

Peripheral: Situated away from the center of a structure.

Periosteum: The thick fibrous membrane that covers bones except at their articulations.

Posterior: Situated in back of or in the back part of.

Primary: First or most important in order of time or development.

Proximal: Nearest closer to any point of reference.

Reticular: Pertaining to or resembling a net.

Secondary: Second or inferior in either time, place, or importance.

Stylet: A wire that is inserted into a hollow instrument, tube, or needle to ensure patency or rigidity.

Superior: Situated above.

Trocar: A sharply pointed tube that fits inside a cannula.

Pathology & Laboratory, 85095, 85102 (Q&A)

APPENDIX C

PRACTICE EXPENSE METHODOLOGY REPORT

Refer to file code HCFA-1111-IFC.

FOR FURTHER INFORMATION CONTACT: **Kenneth Marsalek, (410) 786-4502.** Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), ``Payment for Physicians' Services.'' The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) based on the relative resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work and practice and malpractice expenses.

Under the formula set forth in section 1848(b)(1) of the Act, the amount paid for each service under the physician fee schedule is the product of three factors--(1) A nationally uniform relative value for the service;

For each physician fee schedule service, there are three RVU components--(1) Physician work; (2) practice expense;

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103-432) required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service beginning in 1998. The Balanced Budget Act of 1997 was enacted on August 5, 1997, before publication of the October 1997 final rule on the physician fee schedule (62 FR 59103). Section 4505(a) of the BBA delayed the effective date of the resource-based practice expense RVUs until January 1, 1999, while section 4505(b) provided for a 4-year transition, with resource-based practice expense RVUs becoming fully effective in 2002. In addition, section 4505(d)(1)(A) and (d)(1)(B) of the BBA required us to develop new resource-based practice expense RVUs, and section 4505(d)(1)(C) of the BBA required us to develop a refinement process to be used during each of the 4 years of the transition period.

Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) requires us to establish a process under which we will accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the practice expense component of the physician fee schedule. Section 212(b) states that the process must be available for payments for the 2001 and 2002 physician fee schedules.

In addition, we are soliciting public comment on the criteria that we will consider for survey data submitted between August 2, 2000 and August 1, 2001 for use in computing RVUs for the 2002 physician fee schedule.

Any HCFA-designated specialty group may submit supplemental survey data. (Please see the list below for designated specialties.) However, for survey data submitted for

payments in 2001, we will give priority consideration to specialties that are not represented or are underrepresented in the SMS data. Raw survey data submitted to us between August 2, 2000 and August 1, 2001 will be considered for use in computing practice expense RVUs for CY 2002. The physician practice expense data from surveys that we use in our code-level practice expense calculations are the practice expenses per physician hour in the six practice expense categories--clinical labor, medical supplies, medical equipment, administrative labor, office overhead, and other. Supplemental survey data must include data for these categories. Ideally, we would like to calculate practice expense values with precision; however, we recognize that we must achieve a balance because conducting surveys is expensive and there is a tension between achieving large sample sizes, which increases precision, and smaller ones, which conserves costs

We believe that it is impossible and impractical to set rigid cutoffs for most of these criteria, especially for national representative ness. We are attempting to be as flexible as possible consistent with our goal of obtaining new surveys of practice expense data that are scientifically sound and methodologically consistent with our existing estimates. For instance, a specialty may include different types of physician practices (for example, urban versus rural, academic versus non-academic, interventional versus non-interventional) that exhibit different patterns of practice expense.

We have submitted a copy of this interim final rule to OMB for its' review of the information collection and requirements.

If you comment on these information collection and record keeping requirements, please mail copies directly to the following: Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Attn: John Burke, HCFA-1111-IFC, Room N2-14-26, 7500 Security Boulevard, Baltimore, MD 21244-1850, and, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Eydt, HCFA Desk Officer, HCFA-1111-IFC.

Approved: April 10, 2000.

Donna E. Shalala,

Secretary.