15026 of the Medicare Carriers Manual. An example of such a circumstance could be when a beneficiary in a nursing facility is in immediate need of a diagnostic test and there is a problem, such as extreme obesity, with transporting the individual to a facility.

H. Maxillofacial Prosthetic Services

At present, payment amounts for the maxillofacial prosthetic services (CPT codes 21079 through 21087 and HCPCS codes G0020 and G0021) are determined by individual Medicare carriers. We propose to eliminate the carrier-priced status and establish RVUs for these codes effective for services performed on or after January 1, 1996. We propose to determine fee schedule payment amounts based on the RVUs shown in the table below.

PROPOSED RELATIVE VALUE UNITS FOR MAXILLOFACIAL PROSTHESIS SERVICES

CPT code	Description	Proposed work RVUs	Proposed PE RVUs	Proposed ME RVUs
21079	Impression and custom preparation; interim obturator prosthesis	20.88	27.93	2.25
21080	Impression and custom preparation; definitive obturator prosthesis	23.46	31.38	2.52
21081	Impression and custom preparation; mandibular resection prosthesis	21.38	28.59	2.30
21082	Impression and custom preparation; palatal augmentation prosthesis	19.50	26.08	2.10
21083	Impression and custom preparation; palatal lift prosthesis	18.04	24.13	1.94
21084	Impression and custom preparation; speech aid prosthesis	21.04	28.14	2.28
21085	Impression and custom preparation; oral surgical splint	8.41	11.25	0.90
21086	Impression and custom preparation; auricular prosthesis	23.29	31.15	2.51
21087	Impression and custom preparation; nasal prosthesis	23.29	31.15	2.51
G0020	Impression and custom preparation; surgical obturator prosthesis	12.54	16.77	1.35
G0021	Impression and custom preparation; orbital prosthesis	31.54	42.18	3.39

The work RVUs that we propose were developed by the American Academy of Maxillofacial Prosthetics. We believe they appropriately represent the work involved in these procedures. Because the CPT codes were new in 1991 and the Level 2 HCPCS codes are new in 1995, we have little or no charge data on which to base PE and ME RVUs in accordance with section 1848(c)(2)(C) of the Act. Therefore, we have imputed the PE and ME RVUs from the work RVUs based on the practice cost shares provided by the American Association of Oral and Maxillofacial Surgeons. Those shares are 54.7 percent for PE and 4.4 percent for ME.

We would establish a 90-day global period for these services with the exception of CPT code 21085 and HCPCS code G0020, which we believe require only a 10-day global period. (Under a global period, a single fee is billed and paid for all necessary services normally furnished by the surgeon before, during, and after the procedure within the time period assigned to the service.)

CPT codes 21079 through 21087 and HCPCS codes G0020 and G0021 should be used only if the physician actually designs and prepares the prosthesis. If the physician has designed and prepared the prosthesis and bills a CPT code in the range of 21079 through 21087 and HCPCS codes G0020 and G0021, we will not pay the physician separately for the prosthesis. We consider the cost of the materials used in preparing the prosthesis to be included in the PE portion of the codes.

HCPCS codes L8610 through L8618 identify prostheses that are prepared by an outside laboratory. Payment for HCPCS codes L8610 through L8618 is not made under the physician fee schedule. Payment is made on an individual consideration basis.

CPT codes 21079 through 21087 and HCPCS codes G0020 and G0021 are on the list of codes subject to the site-of-service payment differential since they are predominantly office-based services.

While we welcome any written public comments, we have found from past experience that the most useful comments have followed a particular pattern. They include the CPT code, a clinical description of the service, and a discussion of the work of that service.

Physician work has two components: time and intensity. The clinical analogy for many services can be strengthened by dividing the service into the following three time segments:

- Preservice work—Work performed before the actual procedure such as review of records, solicitation of informed consent, and preparation of equipment. Time spent by the physician dressing, scrubbing, and waiting for the patient should be identified. Preservice work also includes the time spent scrubbing, positioning, or otherwise preparing the patient. For surgical procedures with global periods, commenters should include estimates of the number, time, and type of visits from the day before surgery until the time the patient enters the operating room. The visit when the physician decides to operate and the visits preceding it should not be included in the estimate of preservice work since these services are not included in the Medicare definition of global period.
- Intraservice work—The actual performance of the procedure. For evaluation and management services, this would be described as ''face-to-face'' time in the office setting and ''unit/floor'' time in the inpatient setting. For surgical procedures, the customary term would be ''skin-to-skin'' time or its equivalent for those procedures not beginning with incisions.
- Postservice work—Analysis of data collected from the encounter, preparation of a report, and communication of the results. For procedures with global periods, commenters should identify the time spent by the physician with the patient after the procedure on the same day and whether the patient typically goes home, to an ordinary hospital bed, or goes to the intensive care unit. Commenters should describe the number, time, and type of physician visits from the day after the procedure until the end of the global period.

They should also distinguish inpatient from outpatient visits.

We encourage commenters, in making these estimations, to provide detailed clinical information such as data derived from operating logs, operative reports, and medical charts concerning the length of service, the amount of work performed before and after the service, and the length of stay in the hospital. The usefulness of these data is greatly increased if the data are presented with comparable data for reference services and evidence that justifies that the data presented are nationally representative of the average work involved in furnishing the service. We often receive data that are not helpful to us because the data are not representative of national practices. In