

assist us in making these determinations, we considered the type-of-service classification within the Physicians' Current Procedural Terminology (CPT) and the relationship of services represented by the new codes to surgical services meeting the above-described criteria. We followed a similar process to classify codes that were new in 1995. For the 1996 classification of the new 1995 codes, however, we used 6 months of 1995 data to determine whether they meet the criteria for being considered surgical services. Based on these data, we did not need to reclassify any codes as surgical or nonsurgical.

For 1996, we have classified monthly end-stage renal disease services (HCPCS codes 90918 through 90921) as primary care services. For a full discussion of this classification, see the final rule with comment period entitled "Medicare Program; Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1996" published elsewhere in this Federal Register issue and hereafter referred to as the physician fee schedule final rule.

Also, Addendum B of the physician fee schedule final rule, published elsewhere in this Federal Register issue, lists the RVUs and related information used in determining Medicare payments for HCPCS codes. For the purposes of the physician fee schedule, we have assigned the following surgical, primary care, or other nonsurgical service update indicators to these codes:

Update indicator	Interpretation
S	Surgical services.
P	Primary care services.
N	The physician fee schedule update applies, but the code is not defined as surgical or primary care.
O	The physician fee schedule update does not apply.

The MVPS indicator for a procedure code is identical to the update indicator for codes that have a surgical, primary care, or other nonsurgical service update indicator. However, we consider some codes with an update indicator of "O" to be nonsurgical for the purposes of the MVPS, most notably the clinical diagnostic laboratory codes.

The update indicators for codes new or revised in 1996 are shown in Addendum C of the physician fee schedule final rule, published elsewhere in this Federal Register issue.

II. Analysis of and Responses to Public Comments

In our July 26, 1995 proposed rule (60 FR 38400) concerning revisions to payment policies under the Medicare physician fee schedule for calendar year 1996, we invited public comments on a proposal to use category-specific volume and intensity growth allowances in calculating the default MVPS (60 FR 38416). Since this proposal is related to the MVPS and this notice deals with MVPS issues, we are responding to those comments in this notice instead of in the physician fee schedule, published elsewhere in this Federal Register issue. Our responses to the comments follow:

Comment: Several commenters stated that the use of category-specific volume and intensity growth allowances is counter to the spirit of the MVPS since categories with higher than average volume and intensity growth receive higher MVPS targets, and categories with lower than average volume and intensity growth receive lower targets.

Response: The use of category-specific volume and intensity is more consistent with section 1848(f)(2)(A) of the Act, which describes the calculation of the volume performance standards. Section 1848(f)(2)(A) states that one of the factors in calculating the volume performance standards for all physicians' services and for each category of physicians' services shall be equal to "1 plus the Secretary's estimate of the annual percentage growth (divided by 100) in the volume and intensity of all physicians' services or of the category of physicians' services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year * * *" As stated in our July 26, 1995 proposed rule, although historically the data available to us allowed an accurate estimate of the overall growth in the volume and intensity of physicians' services, they did not allow us to estimate the volume and intensity growth for each individual category of service with the degree of accuracy required for the MVPS calculation. More recent data now allow us to do this. So while it is true that the targets move in the direction of volume and intensity growth, this is a result of the statutory volume performance standard methodology.

Comment: Several commenters stated that the proposed change in methodology does not take into account the "appropriateness" of the differential volume and intensity growth allowances.

Response: As stated in the response to the prior comment, the use of category-specific volume and intensity growth

allowances is more consistent with section 1848(f)(2)(A) of the Act. The appropriateness of the volume performance standards in any given year, or of the statutory methodology itself, can be handled through the MVPS recommendation process. Section 1848(f)(1) of the Act requires the Secretary and the Physician Payment Review Commission to provide recommendations to the Congress on the MVPS for the coming year. The Congress can choose to act on these recommendations or can set the MVPS itself.

Comment: One commenter opposed the use of category-specific volume and intensity growth allowances on the grounds that it was a "stopgap" policy and recommended a legislative change to a single conversion factor and volume performance standard.

Response: As we stated in our July 26, 1995 proposed rule, we proposed this change in our regulations to address immediate problems in the physician fee schedule. The Act does not allow us to create a single conversion factor and volume performance standard for all Medicare physician fee schedule services.

Comment: One commenter believed that we provided no justification for our proposal other than to increase payment for primary care services.

Response: As stated above, the use of category-specific volume and intensity is more consistent with section 1848(f)(2)(A) of the Act. In addition, although for fiscal year 1996 this change in methodology would result in a higher primary care MVPS, this does not necessarily mean the change would have a similar result in future years. The impact on any individual category of physicians' services is dependent on the future relationship between the average volume and intensity growth for that category and for physicians' services overall. If future growth in the volume and intensity of primary care services is lower than overall growth in physicians' services, this change would result in a lower MVPS for primary care services. Similar reasoning applies to the categories of surgical services and nonsurgical services other than primary care.

Comment: Several commenters believed that use of category-specific volume and intensity growth allowances would provide a more accurate baseline against which to compare volume and intensity growth. They also stated that the proposal was more consistent with our use of category-specific estimates of the MVPS factors for the weighted-average increase in physicians' fees and the percentage change in expenditures