

(ii) [Reserved]

(6)(i) CMS establishes criteria for supplemental surveys regarding specialty practice expenses submitted to CMS that may be used in determining practice expense RVUs.

(ii) Any CMS-designated specialty group may submit a supplemental survey.

(iii) CMS will consider for use in determining practice expense RVUs for the physician fee schedule survey data and related materials submitted to CMS by March 1, 2004 to determine CY 2005 practice expense RVUs and by March 1, 2005 to determine CY 2006 practice expense RVUs.

(c) *Malpractice insurance RVUs.* (1) Malpractice insurance RVUs are computed for each service or class of services by applying average malpractice insurance historical practice cost percentages to the estimated average allowed charge during the 1991 base period.

(2) The average historical malpractice insurance percentage for a service or class of services is computed as follows:

(i) Multiply the average malpractice insurance percentage for each specialty by the proportion of a particular service or class of services performed by that specialty.

(ii) Add all the products for all the specialties.

(3) For services furnished in the year 2000 and subsequent years, the malpractice RVUs are based on the relative malpractice insurance resources.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42493, Sept. 15, 1992; 58 FR 63687, Dec. 2, 1993; 62 FR 59102, Oct. 31, 1997; 63 FR 58910, Nov. 2, 1998; 64 FR 59441, Nov. 2, 1999; 65 FR 25668, May 3, 2000; 65 FR 65440, Nov. 1, 2000; 67 FR 43558, June 28, 2002; 68 FR 63261, Nov. 7, 2003; 72 FR 66932, Nov. 27, 2007; 73 FR 69935, Nov. 19, 2008; 76 FR 73471, Nov. 28, 2011; 81 FR 79879, Nov. 14, 2016; 81 FR 80553, Nov. 15, 2016]

§ 414.24 Publication of RVUs and direct PE inputs.

(a) *Definitions.* For purposes of this section, the following definitions apply:

Existing code means a code that is not a new code under paragraph (c)(2) of this section, and includes codes for which the descriptor is revised and

codes that are combinations or subdivisions of previously existing codes.

New code means a code that describes a service that was not previously described or valued under the PFS using any other code or combination of codes.

(b) *Revisions of RVUs and Direct PE Inputs.* For valuations for calendar year 2017 and beyond, CMS publishes, through notice and comment rule-making in the FEDERAL REGISTER (including proposals in a proposed rule), changes in RVUs or direct PE inputs for existing codes.

(c) *Establishing RVUs and Direct PE inputs for new codes—(1) General rule.* CMS establishes RVUs and direct PE inputs for new codes in the manner described in paragraph (b) of this section.

(2) *Exception for new codes for which CMS does not have sufficient information.* When CMS determines for a new code that it does not have sufficient information to include proposed RVUs or direct PE inputs in the proposed rule, but that it is in the public interest for Medicare to use a new code during a payment year, CMS will publish in the FEDERAL REGISTER RVUs and direct PE inputs that are applicable on an interim basis subject to public comment. After considering public comments and other information on interim RVUs and PE inputs for the new code, CMS publishes in the FEDERAL REGISTER the final RVUs and PE inputs for the code.

(d) *Values for local codes (HCPCS Level 3).* (1) Carriers establish relative values for local codes for services not included in HCPCS levels 1 or 2.

(2) Carriers must obtain prior approval from CMS to establish local codes for services that meet the definition of “physician services” in § 414.2.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 79 FR 68003, Nov. 13, 2014]

§ 414.26 Determining the GAF.

CMS establishes a GAF for each service in each fee schedule area.

(a) *Geographic indices.* CMS uses the following indices to establish the GAF:

(1) An index that reflects one-fourth of the difference between the relative value of physicians’ work effort in each of the different fee schedule areas as