(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 rulemaking 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

determined under § 414.22(a) and the national average of that work effort.

(2) An index that reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in each of the different fee schedule areas as determined under § 414.22(b) compared to the national average of those costs.

(3) An index that reflects the relative costs of malpractice expenses in each of the different fee schedule areas as determined under § 414.22(c) compared to the national average of those costs.

(b) *Class-specific practice cost indices.* If the application of a single index to different classes of services would be substantially inequitable because of differences in the mix of goods and services comprising practice expenses for the different classes of services, more than one index may be established under paragraph (a)(2) of this section.

(c) *Adjusting the practice expense index to account for the Frontier State floor—* (1) *General criteria.* Effective on or after January 1, 2011, CMS will adjust the practice expense index for physicians' services furnished in qualifying States to recognize the practice expense index floor established for Frontier States. A qualifying State must meet the following criteria:

(i) At least 50 percent of counties located within the State have a population density less than 6 persons per square mile.

(ii) The State does not receive a nonlabor related share adjustment determined by the Secretary to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(2) *Amount of adjustment.* The practice expense value applied for physicians' services furnished in a qualifying State will be not less than 1.00.

(3) *Process for determining adjustment.* (i) CMS will use the most recent population estimate data published by the U.S. Census Bureau to determine county definitions and population density. This analysis will be periodically revised, such as for updates to the decennial census data.

(ii) CMS will publish annually a listing of qualifying Frontier States receiving a practice expense index floor attributable to this provision.

(d) *Computation of GAF.* The GAF for each fee schedule area is the sum of the physicians' work adjustment factor, the practice expense adjustment factor, and the malpractice cost adjustment factor, as defined in this section:

(1) The geographic physicians' work adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the work component and the geographic physicians' work index value established under paragraph (a)(1) of this section.

(2) The geographic practice expense adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the practice expense component, multiplied by the geographic practice cost index (GPCI) value established under paragraph (a)(2) of this section.

(3) The geographic malpractice adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the malpractice component, multiplied by the GPCI value established under paragraph (a)(3) of this section.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 75 FR 73616, Nov. 29, 2010]

§ 414.28 Conversion factors.

CMS establishes CFs in accordance with section 1848(d) of the Act.

(a) *Base-year CFs.* CMS established the CF for 1992 so that had section 1848 of the Act applied during 1991, it would have resulted in the same aggregate amount of payments for physician services as the estimated aggregate amount of these payments in 1991, adjusted by the update for 1992 computed as specified in § 414.30.

(b) *Subsequent CFs.* For calendar years 1993 through 1995, the CF for each year is equal to the CF for the previous year, adjusted in accordance with § 414.30. Beginning January 1, 1996, the CF for each calendar year may be further adjusted so that adjustments to the fee schedule in accordance with section 1848(c)(2)(B)(ii) of the Act do not cause total expenditures under the fee schedule to differ by more than $20 million from the amount that would