and 2004 and 2005 allowed expenditures. Because we have incomplete actual expenditure data for 2004, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the update adjustment factor for future years.

We are using figures from Table 23 in the statutory formula illustrated below:

UAF = Update Adjustment Factor
$Target_{04}$ = Allowed Expenditures for 2004 or $77.1 billion
$Actual_{04}$ = Estimated Actual Expenditures for 2004 = $84.9 billion
$Target_{4/96–12/04}$ = Allowed Expenditures from 4/1/1996–12/31/2004 = $531.8 billion
$Actual_{4/96–12/04}$ = Estimated Actual Expenditures from 4/1/1996–12/31/2003 = $545.5 billion
SGR_{05} = 4.3 percent (1.043)

Section 1848(d)(4)(D) of the Act indicates that the UAF determined under section 1848(d)(4)(B) of the Act for a year may not be less than −0.070 or greater than 0.03. Since −0.120 is less than −0.070, the UAF for 2005 will be −0.070.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1 should be added to the UAF determined under section 1848(d)(4)(B) of the Act. Thus, adding 1 to −0.070 makes the update adjustment factor equal to 0.930.

IX. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

A. Medicare Sustainable Growth Rate

The SGR is an annual growth rate that applies to physicians' services paid by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the physician fee schedule update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services.

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries.

(3) The estimated projected growth in real GDP per capita.

(4) The estimated change in expenditures due to changes in law or regulations.

In general, section 1848(f)(3) of the Act requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. (There were also provisions in the Act to adjust the FY 1998 and FY 1999 SGRs. See the February 28, 2003 **Federal Register** (68 FR 9567) for a discussion of these SGRs). Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule, we are making our preliminary estimate of the 2005 SGR, a revision to the 2004 SGR, and our final revision to the 2003 SGR.

B. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that ''the term ''physicians' services'' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.'' We published a definition of physicians' services for use in the SGR in the **Federal Register** (66 FR 55316) on November 1, 2001. We defined physicians' services to include many of the medical and other health services listed in section 1861(s) of the Act. For purposes of determining allowed expenditures, actual expenditures, and SGRs through December 31, 2002, we have specified that physicians' services include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers (and those paid through intermediaries where specified):

- Physicians' services.
- Services and supplies furnished incident to physicians' services.
- Outpatient PT services and outpatient OT services.
- Antigens prepared by, or under the direct supervision of, a physician.
- Services of PAs, certified registered nurse anesthetists, CNMs, clinical psychologists, clinical social workers, NPs, and CNSs.
- Screening tests for prostate cancer, colorectal cancer, and glaucoma.
- Screening mammography, screening pap smears, and screening pelvic exams.
- Diabetes outpatient self-management training services.
- Medical nutrition therapy services.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including outpatient diagnostic laboratory tests paid through intermediaries).
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.

Sections 611 through 613 of the MMA, respectively, modified section 1861(s) of the Act to add Medicare coverage for an initial preventive exam,

CV screening blood tests, and diabetes screening tests. We believe that these services are commonly performed or furnished by a physician or in a physician's office and are including them in the definition of physicians' services for purposes of the SGR.

Comment: We received a number of comments requesting that we use our administrative authority to remove drugs from the SGR. According to one of these comments, drugs are not physicians' services and should never have been included in the SGR. One of these comments indicated that the SGR ''is a seriously flawed formula that will continue to require frequent Congressional intervention to avoid payment cuts * * *'' According to this comment, ''the Administration should reduce the price tag and help pave the way for an appropriate long-term solution by removing drugs from the SGR pool.'' We also received a number of comments suggesting that we use our administrative authority to adjust the SGR for changes in spending associated with national coverage determinations (NCDs).

Response: We remain concerned about forecasts of reductions in physician fees and will carefully consider the issues raised by the comments when we make changes to the physician fee schedule for 2006. We believe that the physician payment system should be structured to control costs and achieve predictable and stable changes to Medicare's rates while being equitable to physicians. We note that administrative changes affecting the SGR would have significant long-term cost implications but will not have an impact on the update for 2006 or the subsequent few years. Therefore, without a statutory change, there will still be a reduction in physicians' fee schedule rates for 2006 and subsequent years. Towards those goals, we have already taken several actions that will improve Medicare's physician payment system:

- Using multifactor productivity in place of labor productivity in the MEI beginning in 2003. This change increased the physician fee schedule update by 0.7 percentage points for 2003 and was estimated to increase Medicare spending by $14.5 billion over 10 years.
- Increasing the weight of malpractice costs in the MEI from 3.2 to 3.9 percent, a 21 percent increase beginning in 2004.
- Incorporating an increase in malpractice premiums of 16.9 percent into the 2004 MEI and 23.9 percent into the 2005 MEI. The increased weight for malpractice in the MEI makes the index a more accurate representation of inflation in physician office costs.

C. Preliminary Estimate of the SGR for 2005

Our preliminary estimate of the 2005 SGR is 4.3 percent. We first estimated the 2005 SGR in March and made the estimate available to the Medicare Payment Advisory Commission and on our Web site. Table 24 shows that March 2004 and our current estimates of the factors included in the 2005 SGR.

TABLE 24:

Statutory Factors	March Estimate	Current Estimate
Fees	2.6 percent (1.026)	1.3 percent (1.013)
Enrollment	-0.2 percent (0.998)	-0.3 percent (0.997)
Real Per Capita GDP	2.2 percent (1.022)	2.2 percent (1.022)
Law and Regulation	0.0 percent (1.000)	1.0 percent (1.010)
Total	4.6 percent (1.046)	4.3 percent (1.043)

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, $1.013 \times 0.997 \times 1.022 \times 1.010 = 1.37$). A more detailed explanation of each figure is provided below in section H.1.

D. Revised Sustainable Growth Rate for 2004

Our current estimate of the 2004 SGR is 7.0 percent. Table 25 shows our preliminary estimate of the 2004 SGR that was published in the **Federal Register** on November 7, 2003 (68 FR 63249) and our current estimate.

TABLE 25:

Statutory Factors	November 7, 2003 Estimate	Current Estimate
Fees	2.7 percent (1.027)	1.4 percent (1.014)
Enrollment	1.7 percent (1.017)	1.7 percent (1.017)
Real Per Capita GDP	2.8 percent (1.028)	2.2 percent (1.022)
Law and Regulation	0.0 percent (1.000)	1.5 percent (1.015)
Total	7.4 percent (1.074)	7.0 percent (1.070)

A more detailed explanation of each figure is provided below in section H.2.

E. Final Sustainable Growth Rate for 2003

The SGR for 2003 is 7.3 percent. Table 26 shows our preliminary estimate of the SGR published in the **Federal Register** on December 31, 2002 (67 FR 80027), our revised estimate published in the **Federal Register** on November 7, 2003 (67 FR 63249) and the final figures

determined using the latest available data.

TABLE 26:

Statutory Factors	12/31/02 Estimate	11/7/03 Estimate	Final
Fees	2.9 percent (1.029)	2.8 percent (1.028)	2.8 percent (1.028)
Enrollment	1.2 percent (1.012)	2.4 percent (1.024)	2.3 percent (1.023)
Real Per Capita GDP	3.3 percent (1.033)	1.4 percent (1.014)	2.0 percent (1.020)
Law and Reg	0.0 percent (1.000)	0.0 percent (1.000)	0.0 percent (1.000)
Total	7.6 percent (1.076)	6.7 percent (1.067)	7.3 percent (1.073)

A more detailed explanation of each figure is provided below in section H.2.

F. Calculation of 2005, 2004, and 2003 Sustainable Growth Rates

1. Detail on the 2005 SGR

All of the figures used to determine the 2005 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent physician fee schedule updates.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2005

This factor is calculated as a weighted average of the 2005 fee increases for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the physician fee schedule are estimated to account for approximately 83.9 percent of total allowed charges included in the SGR in 2005 and are updated using the MEI. The MEI for 2005 is 3.1 percent. Diagnostic laboratory tests are estimated to represent approximately 7.1 percent of Medicare allowed charges included in the SGR for 2005. Medicare payments for these tests are updated by the Consumer Price Index for Urban Areas (CPI–U). However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from 2004 through 2008.

Drugs are estimated to represent 9.0 percent of Medicare allowed charges included in the SGR in 2005. As indicated earlier in this final rule, sections 303 and 304 of the MMA require Medicare to pay for most drugs at 106 percent of ASP beginning January 1, 2005. We estimated a weighted average change in fees for drugs included in the SGR using the ASP plus 6 percent pricing methodology of −14.7 percent for 2005. Table 27 shows the weighted average of the MEI, laboratory and drug price changes for 2005.

TABLE 27:

	Weight	Update
Physician	0.839	3.1
Laboratory	0.071	0.0
Drugs	0.090	-14.7
Weighted Average	1.000	1.3

We estimate that the weighted-average increase in fees for physicians' services in 2005 under the SGR (before applying any legislative adjustments) will be 1.3 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2004 to 2005

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from 2004 to 2005. Services provided to Medicare+Choice (M+C) plan enrollees are outside the scope of the SGR and are excluded from this estimate. OACT estimates that the average number of Medicare Part B fee-for-service enrollees will decrease by 0.3 percent from 2004 to 2005. Table 28 illustrates how this figure was determined.

TABLE 28:

	2004	2005
Overall	39.041 million	39.547 million
Medicare+Choice	4.671 million	5.275 million
Net	34.370 million	34.272 million
Percent Increase		-0.3 percent

An important factor affecting fee-for-service enrollment is beneficiary enrollment in M+C plans. Because it is difficult to estimate the size of the M+C enrollee population before the start of a calendar year, at this time we do not know how actual enrollment in M+C plans will compare to current estimates. For this reason, the estimate may change substantially as actual Medicare fee-for-service enrollment for 2005 becomes known.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2005

We estimate that the growth in real per capita GDP from 2004 to 2005 will be 2.2 percent. Our past experience indicates that there have also been large changes in estimates of real per capita GDP growth made before the year begins and the actual change in GDP computed after the year is complete. Thus, it is likely that this figure will change as actual information on economic performance becomes available to us in 2005.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in CY 2005 Compared With CY 2004

There are a number of statutory provisions that will affect the 2005 SGR. As indicated above, sections 303 and 304 of the MMA changed Medicare payment for drugs. These provisions also changed Medicare payments for the administration of drugs. Section 303(a)(1) amended section 1848(c)(2) of the Act to require the Secretary to make a number of changes that increased Medicare payment for drug administration beginning January 1, 2004. These changes permanently increased Medicare payments for drug administration by a weighted average of 110 percent. Section 303(a)(4) of the MMA required an additional transitional adjustment (temporary increase) to Medicare's payment for drug administration of 32 percent for 2004 and 3 percent for 2005. The change in the transitional adjustment of 32 percent for 2004 to 3 percent for 2005 would reduce Medicare payments for drug administration between 2004 and 2005. However, some of this reduction will be lessened because we are also adopting changes to the codes and payment amounts for drug administration based on recommendations from the AMA's CPT Editorial Panel and Relative Value Update Committee (RUC), under the authority of section 1848(c)(2)(J) of the Act. We are further increasing physician fee schedule payments by paying separately for injections provided on the same day as another physician fee schedule service. We are further increasing physician fee schedule payments by paying separately for injections provided on the same day as another physician fee schedule service. We estimate that changes to our policy on injections and the changes to our drug administration payments taken together will increase physician spending by 0.2 percent.

We are also adjusting the SGR to account for OACT's assumptions about predicted physician behavior in response to the payment reductions. OACT assumes that reduced fees are likely to be met by a combination of an increase in volume and a shift in the mix or intensity of services furnished to Medicare beneficiaries so as to offset 30 percent of the payment reduction that would otherwise occur. Because OACT assumes that physicians will offset some of the loss in payments that will occur from changes in Medicare payments for drugs (as described earlier) and drug administration and the change in payment can be attributed to a change in law, we are increasing the SGR by 0.4 percent for this factor. (Discussion may change based on recent decisions.)

There are several other statutory provisions that are estimated to increase Medicare spending for physicians' services under the SGR. Section 413(a) of the MMA establishes a 5 percent increase in the physician fee schedule payment for services provided in physician scarcity areas. Section 413(b) improves the procedures for paying the 10 percent physician fee schedule bonus payment for services provided in health professional shortage areas. We estimate that the provisions of section 413 will increase Medicare physician fee schedule payments by 0.1 percent.

Sections 611 through 613 of the MMA, respectively, provide Medicare coverage for an initial preventive physical examination, CV and diabetes screening tests. We estimate that new Medicare coverage for these preventive services will increase spending for physicians' services under the SGR by 0.3 percent. Taken together, we estimate that all of the statutory provisions for 2005 will increase Medicare spending for physicians' services by 0.5 percent.

Comment: We received comments concerned that we will underestimate the costs associated with the initial preventive physical examination. These comments suggested that we should account for ''both spending due to use of the new or expanded benefit, as well as additional services triggered by implementation of the new benefit.'' We received other comments concerned that we will underestimate the cost of CV and diabetes screening tests because we will use the national coverage determination (NCD) process to decide if any additional tests may be eligible for coverage. The commenters have this concern because we do not adjust the SGR for NCDs.

Response: Our estimates of the costs of the initial preventive physical exam and the CV and diabetes screening tests account for utilization of other Medicare services (preventive and nonpreventive) that may result from coverage of the new preventive services. We also note that our current estimates of the initial preventive examination and CV and diabetes screening tests are based only on our projections without any data on actual use of the benefits. The statute requires us to revise our current estimate of the 2005 SGR no later than November 1, 2005 and to make a final revision to our estimate no later than November 1, 2006. At the time we make the final revision to the 2005 SGR, we will have complete data on use of the new preventive services that will enable us to more accurately reflect these costs in the SGR.

With respect to the comments about use of the NCD process to establish additional CV and diabetes screening tests that will be eligible for Medicare coverage, the regulation lists the common types of tests that are currently

used to screen patients for these conditions. Our adjustment to the SGR will cover all of the costs associated with these new Medicare covered screening tests. However, if we use the NCD process to cover additional tests, we will consider this issue further.

2. Detail on the 2004 SGR

A more detailed discussion of our revised estimates of the four elements of the 2004 SGR follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2004

This factor was calculated as a weighted average of the 2004 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

We estimate that services paid using the physician fee schedule account for approximately 83.7 percent of total allowed charges included in the SGR in 2004. These services were updated using the 2004 MEI of 2.9 percent. We estimate that diagnostic laboratory tests represent approximately 7.1 percent of total allowed charges included in the SGR in 2004. Medicare payments for these tests are updated by the CPI–U. However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from 2004 through 2008. We estimate that drugs represent 9.2 percent of Medicare allowed charges included in the SGR in 2004. Historically, Medicare paid for drugs under section 1842(o) of the Act at 95 percent of average wholesale price (AWP). However, with some exceptions, sections 303 and 304 of the MMA generally require Medicare to pay for drugs at 85 percent of the AWP determined as of April 1, 2003 or a specified percentage of AWP based on studies by the Government Accountability Office and the Office of the Inspector General in 2004. (We implemented section 303 and 304 of the MMA in an interim final rule published in the **Federal Register** on January 7, 2004 (see 69 FR 1086). Taking sections 303 and 304 of the MMA into account, we estimate a weighted average change in fees for drugs included in the SGR of −11.7 percent for 2004. Table 29 shows the weighted average of the MEI, laboratory and drug price changes for 2004.

TABLE 29:

	Weight	Update
Physician	0.837	2.9
Laboratory	0.071	0.0
Drugs	0.092	-11.7
Weighted Average	1.000	1.4

After taking into account the elements described in Table 29, we estimate that the weighted-average increase in fees for physicians' services in 2004 under the SGR (before applying any legislative adjustments) will be 1.4 percent. Our November 7, 2003 estimate of this factor was 2.7 percent. The reduction from 2.7 percent to our current estimate of 1.4 percent is primarily due to application of the drug pricing changes required by sections 303 and 304 of the MMA.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2003 to 2004

OACT estimates that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) increased by 1.7 percent in 2004. Table 30 illustrates how we determined this figure.

TABLE 30:

	2003	2004
Overall	38.465 million	39.041 million
Medicare+Choice	4.655 million	4.671 million
Net	33.810 million	34.370 million
Percent Increase		1.7 percent

OACT's estimate of the 1.7 percent change in the number of fee-for-service enrollees, net of M+C enrollment for 2004 compared to 2003, is the same as our original estimate published in the November 7, 2003 final rule (68 FR 63250). While our current projection based on data from 8 months of 2004 is the same as our original estimate when we had no data, it is still possible that our final estimate of this figure will be different once we have complete information on 2004 fee-for-service enrollment.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2004

We estimate that the growth in real per capita GDP will be 2.2 percent for 2004. Our past experience indicates that there have also been large differences between our estimates of real per capita GDP growth made prior to the year's end and the actual change in this factor. Thus, it is likely that this figure will change further as complete actual information on 2004 economic performance becomes available to us in 2005.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in 2004 Compared With 2003

There are four statutory provisions that are increasing 2004 Medicare spending relative to 2003. Section 412 of the MMA established a floor of 1.0 on adjustments to the physician work relative value unit for the geographic practice cost index (GPCI) for the years 2004 through 2006. Section 602 of the MMA increases the GPCIs for work, practice expense, and malpractice in Alaska to 1.67. Because these provisions increase the work GPCIs that are below 1.0 to 1.0 and, for services in Alaska, we estimate that sections 412 and 602 of the MMA are increasing 2004 Medicare spending included in the SGR by 0.6 percent. Sections 303 and 304 of the MMA increased Medicare's payments for drug administration in 2004. It further exempted the increases in payment from the budget neutrality provisions of section 1848(c)(2) of the Act. We estimate the section 303 and 304 provisions will increase spending for physicians' services by 0.8 percent in 2004. Taken together, we estimate that statutory provisions are increasing 2004 spending for physicians' services by 1.5 percent (after accounting for rounding).

3. Detail on the 2003 SGR

A more detailed discussion of our revised estimates of the four elements of the 2003 SGR follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2003

This factor was calculated as a weighted average of the 2003 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

Services paid using the physician fee schedule accounted for approximately 83.0 percent of total Medicare allowed charges included in the SGR for 2003 and are updated using the MEI. The MEI for 2003 was 3.0 percent. Diagnostic laboratory tests represent approximately 7.2 percent of total Medicare allowed charges included in the SGR and are updated by the CPI–U. The CPI–U applied to payments for laboratory services for 2003 was 1.1 percent. Drugs represented approximately 9.8 percent of total Medicare allowed charges included in the SGR for 2003. According to section 1842(o) of the Act, Medicare pays for drugs based on 95 percent of AWP. Using wholesale pricing information and Medicare utilization for drugs included in the SGR, we estimate a weighted average fee increase for drugs of 1.9 percent for 2003. Table 31 shows the weighted average of the MEI, laboratory, and drug price increases for 2003.

TABLE 31:

	Weight	Update
Physician	0.830	3.0
Laboratory	0.072	1.1
Drugs	0.098	1.9
Weighted Average	1.000	2.8

After taking into account the elements described in Table 31, we estimate that the weighted-average increase in fees for physicians' services in 2003 under the SGR (before applying any legislative adjustments) was 2.8 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2002 to 2003

We estimate the increase in the number of fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) from 2002 to 2003 was 2.3 percent. Our calculation of this factor is based on complete data from 2003. Table 32 illustrates the calculation of this factor.

TABLE 32:

	2002	2003
Overall	38.049 million	38.465 million
Medicare+Choice	5.005 million	4.655 million
Net	33.044 million	33.810 million
Percent Increase		2.3 percent

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2003

We estimate that the growth in real per capita GDP was 2.0 percent in 2003. This figure is a final one based on complete data for 2003.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in 2003 Compared With 2002

There are no statutory or regulatory changes that affect Medicare expenditures for services included in the SGR in 2003.

X. Anesthesia and Physician Fee Schedule Conversion Factors (CF) for Calendar Year 2005

The 2005 physician fee schedule CF will be $37.8975. The 2005 national average anesthesia conversion factor is $17.7594.

Physician Fee Schedule Conversion Factor

Under section 1848(d)(1)(A) of the Act, the physician fee schedule CF is equal to the CF for the previous year multiplied by the update determined under section 1848(d)(4) of the Act. Using this formula would result in a 3.3 percent reduction to the physician fee schedule CF for 2005. However, section 601 of the MMA amended section 1848(d) of the Act to specify that the update to the single CF for 2004 and 2005 will not be less than 1.5 percent. Because the statutory formula will yield a 3.3 percent reduction to the 2005 physician fee schedule CF and the amendments to the statute indicate that the update for 2005 cannot be less than 1.5 percent, we are increasing the physician fee schedule conversion factor by 1.5 percent.

We illustrate the calculation for the 2005 physician fee schedule CF in Table 33 below.

TABLE 33:

2004 Conversion Factor	$37.3374
2005 Update	1.5 percent (1.015)
2005 Conversion Factor	$37.8975

• *Anesthesia Fee Schedule Conversion Factor*

Anesthesia services do not have RVUs like other physician fee schedule services. Therefore, we account for any necessary RVU adjustments through an adjustment to the anesthesia fee schedule CF. The only adjustment we are applying to the anesthesia fee schedule CF for 2005 is the physician fee schedule update. We used the following figures to determine the anesthesia fee schedule CF (see Table 34).

TABLE 34:

2004 Anesthesia Conversion Factor	$17.4969
2005 Update	1.5 percent (1.0150)
2005 Anesthesia Conversion Factor	$17.7594

XI. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2005 is 3.1 percent.

Therefore, for CY 2005, the payment amount for HCPCS code ''Q3014, telehealth originating site facility fee'' is 80 percent of the lesser of the actual charge or $21.86. The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown in Table 35.

TABLE 35:

Facility Fee	MEI Increase	Period
$20.00	N/A	10/01/2001 - 12/31/2002
$20.60	3.0%	01/01/2003 - 12/31/2003
$21.20	2.9%	01/01/2004 - 12/31/2004
$21.86	3.1%	01/01/2005 - 12/31/2005

XII. Provisions of the Final Rule

The provisions of this final rule restate the provisions of the August 2004 proposed rule, except as noted elsewhere in the preamble.

XIII. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds

good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We believe that providing a notice and comment procedure with regard to the RNHCI home benefit would be contrary to the public interest. The RNHCI home benefit provisions were added by the Congress to get a RNHCI benefit to those beneficiaries who are confined to the home. We believe that the Congress intended to provide the benefit to the homebound RNHCI beneficiaries as means of providing a similar home option as is offered to the general Medicare population. However, this expanded benefit is, by statute, a time limited benefit. Any delay in implementation could prevent beneficiaries from utilizing this expanded benefit at all or could seriously impinge on the amount of time they can use the benefit. Therefore, we find good cause to waive notice and comment procedures as contrary to the public interest with regard to the RNHCI home benefit. We are, however, providing a 60-day period for public comment.

XIV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether OMB should approve an information collection, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Section 403.766 Requirements for Coverage/Payment of Home Services

In summary, § 403.766 states the RNHCI provider must submit a written letter of intent to us if they choose to participate in offering the home service benefit.

The burden associated with this requirement is the time and effort of the RNHCI provider to prepare and submit a letter of intention. It is estimated that this two-sentence letter should take no longer than 15 minutes to prepare and submit. There are currently 16 RNHCI providers and, if all elected to participate, it would result in a one-time burden of 4 hours.

We have submitted a copy of this final rule with comment to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

Section 410.16 Initial Preventive Physical Examination: Conditions for Limitations on Coverage

In summary, § 410.16 requires the furnishing of education, counseling and referral services as part of an initial preventive physical examination, a written plan for obtaining the appropriate screening and other preventive services which are also covered as separate Medicare B Part services.

The burden associated with this requirement is the time required of the physician or practitioner to provide beneficiaries with education, counseling, and referral services and to develop and provide a written plan for obtaining screening and other preventive services.

While these requirements are subject to the PRA; we believe the burden associated with these requirements to be usual and customary business practice; therefore, the burden for this collection requirement is exempt under 5 CFR 1320.3(b)(2)&(3).

Section 411.404 Criteria for Determining That a Beneficiary Knew That Services Were Excluded From Coverage as Custodial Care or as Not Reasonable and Necessary

In summary, § 411.404 requires that written notice must be given to a beneficiary, or someone acting on his or her behalf, that the services were not covered because they did not meet Medicare coverage guidelines.

Although this section is subject to the PRA, the burden associated with this requirement is currently captured and accounted for in two currently approved information collections under OMB numbers 0938–0566 and 0938–0781.

Section 418.205 Special Requirements for Hospice Pre-Election Evaluations and Counseling Services

In summary, § 418.205 states that written documentation is required and must be maintained for referral requests and services furnished.

While these information collection requirements are subject to the PRA, the burden associated with them is exempt as defined in 5 CFR 1320.3(b)(2).

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following: Centers for Medicare & Medicaid Services Office of Strategic Operations and Regulatory Affairs, Attn: Melissa Musotto (CMS–1429–FC) Room C5–13–28, 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: Christopher Martin, CMS Desk Officer (CMS–1429–P), *Christopher Martin@omb.eop.gov.* FAX (202) 395–6974.

XV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the ''DATES'' section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XVI. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980 Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibilities of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for final rules with economically significant effects (that is, a final rule that would have an annual effect on the economy of $100 million or more in any 1 year, or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities).

As indicated in more detail below, we expect that the physician fee schedule provisions included in this final rule will redistribute more than $100 million in 1 year. We also anticipate that the combined effect of several provisions of the MMA implemented in this final rule will increase spending by more than $100 million. Other MMA provisions implemented in this final rule are expected to reduce spending by more than $100 million. We are considering this final rule to be economically significant because its provisions are expected to result in an increase, decrease or aggregate redistribution of Medicare spending that will exceed $100 million. Therefore, this final rule is a major rule and we have prepared a regulatory impact analysis.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds. We have determined that this final rule would have minimal impact on small hospitals located in rural areas. Of 517 hospital-based ESRD facilities located in rural areas, only 40 are affiliated with hospitals with fewer than 100 beds.

For purposes of the RFA, physicians, nonphysician practitioners, and suppliers are considered small businesses if they generate revenues of $6 million or less. Approximately 95 percent of physicians are considered to be small entities. There are about 875,000 physicians, other practitioners and medical suppliers that receive Medicare payment under the physician fee schedule. There are in excess of 20,000 physicians and other practitioners that receive Medicare payment for drugs. As noted previously in this final rule and described further below, we are implementing significant changes to the payments for drugs.) The 20,000 physicians that receive payments for drugs are generally concentrated in the specialties of oncology, urology, rheumatology and infectious disease. Of the physicians in these specialties, approximately 40 percent are in oncology and 45 percent in urology.

For purposes of the RFA, approximately 98 percent of suppliers of durable medical equipment (DME) and prosthetic devices are considered small businesses according to the Small Business Administration's (SBA) size standards. We estimate that 106,000 entities bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) each year. Total annual estimated Medicare revenues for DME suppliers exceed approximately $4.0 billion. Of this amount, approximately $1.6 billion are for DME drugs. These suppliers will be affected by the payment changes being made in this final rule for drugs.

In addition, most ESRD facilities are considered small entities, either based on nonprofit status, or by having revenues of $29 million or less in any year. We consider a substantial number of entities to be affected if the rule is estimated to impact more than 5 percent of the total number of small entities. Based on our analysis of the 785 nonprofit ESRD facilities considered small entities in accordance with the above definitions, we estimate that the combined impact of the changes to payment for renal dialysis services included in this rule would have a 1.6 percent increase in payments relative to current composite rate payments.

The analysis and discussion provided in this section, as well as elsewhere in this final rule, complies with the RFA requirements. Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. Medicare beneficiaries are considered to be part of the private sector for this purpose. The net impact of the provisions of this rule, including those related to the MMA, are estimated to result in a savings to beneficiaries of nearly $485 million for FY 2005. However, we note that this savings figure compares FY 2005 beneficiary costs occurring as a result of provisions of this final rule to FY 2005 estimated beneficiary costs in the absence of final rule implementation (that is, the savings figure compare beneficiary costs with implementation of the ASP drug payment provisions to continuing the AWP drug payment methodology). The specific effects of the provisions being implemented in this final rule are explained in greater detail below.

We have examined this final rule in accordance with Executive Order 13132 and have determined that this regulation would not have any significant impact on the rights, roles, or responsibilities of State, local, or tribal governments.

We have prepared the following analysis, which, together with the information provided in the rest of this preamble, meets all assessment requirements. It explains the rationale for and purposes of the rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we use to minimize the burden on small entities. As indicated elsewhere in this final rule, we are refining resource-based practice expense RVUs and making a variety of other changes to our regulations, payments, or payment policy to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We are also implementing several changes resulting from the MMA, including changes to Medicare payment rates for outpatient drugs, changes to the payment for renal dialysis services, creating new preventive health care benefits and creating incentive payment program improvements for physician scarcity.

We are providing information for each of the policy changes in the relevant sections of this final rule. We are unaware of any relevant Federal rules that duplicate, overlap or conflict with this final rule. The relevant sections of this final rule contain a description of significant alternatives if applicable.

A. Resource-Based Practice Expense and Malpractice Relative Value Units

Under section 1848(c)(2) of the Act, adjustments to RVUs may not cause the amount of expenditures to differ by more than $20 million from the amount of expenditures that would have resulted without such adjustments. We are implementing several changes that would result in a change in expenditures that would exceed $20 million if we made no offsetting adjustments to either the conversion factor or RVUs.

With respect to practice expense RVUs, our policy has been to meet the budget-neutrality requirements in the statute by incorporating a rescaling adjustment in the practice expense methodologies. That is, we estimate the aggregate number of practice expense RVUs that will be paid under current and revised policy in CY 2005. We

apply a uniform adjustment factor to make the aggregate number of revised practice expense RVUs equal the number estimated that would be paid under current policy. While we are continuing to apply this policy for general changes in coding and RVUs, we are increasing aggregate physician fee schedule payments to account for the higher payments for drug administration. These increases in payment are being made under the authority of section 1848(c)(2)(J) of the Act that exempts the changes in payments for drug administration from the budget neutrality requirements of section 1848(c)(2)(B)(iv) of the Act.

Table 36 shows the specialty level impact on payment of the practice expense and malpractice RVU changes being implemented for CY 2005. Our estimates of changes in Medicare revenues for physician fee schedule services compare payment rates for 2005 with payment rates for 2004 using 2003 Medicare utilization for both years. We are using 2003 Medicare claims processed and paid through June 30, 2004, that we estimate are 98.5 percent complete, and have adjusted the figures to reflect a full year of data. Thus, because we are using a single year of utilization, the estimated changes in revenues reflect payment changes only between 2004 and 2005. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown here. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the physician fee schedule. For instance, independent laboratories receive approximately 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the physician fee schedule. The table shows only the payment impact on physician fee schedule services.

The column labeled ''NPRM Impacts'' shows the effect of the changes in payment attributable to practice expense and malpractice RVUs from the proposed rule. (*See* 69 FR 47556 through 47559 for a complete description of the payment changes shown in this column). We have also made some additional changes to the practice expense and malpractice RVUs since the proposed rule in response to comments and additional information that became available to us during the comment period. The additional changes in payment based on further refinements of the practice expense RVUs generally have no specialty level impact. The 1 percent increase in payment for vascular surgery shown in the practice expense refinements column is attributed to substitution of a vascular ultrasound room for a general ultrasound room in the equipment resources for CPT code 93880. Similarly, the increase in practice expense RVUs for diagnostic testing facilities is also attributable to the increase in payment for 93880 and 93925 due to the substitution of a vascular ultrasound room for a general ultrasound room in the equipment resources.

The column labeled ''Additional Malpractice RVU Refinements'' show the additional impact of changes in the malpractice expense RVUs since the proposed rule on total payment for physician fee schedule services. As explained earlier, we are making several changes to malpractice RVUs that will change the impacts we illustrated in the proposed rule. We are removing assistants-at-surgery from the Medicare utilization that goes into determining the malpractice RVUs. Relative to the proposed rule, this change will increase total payments to neurosurgeons by nearly 1 percent. We also increased the ISO risk classification for the all physician crosswalk used for podiatry increasing their payments by 1 percent relative to the proposed rule. Several specialty groups, including dermatology commented that the major surgery risk factor should not be used for the dermatology codes. Relative to the proposed rule, payments to dermatologists will decrease by approximately 1 percent as a result of this change. The changes also increase payment to the specialty of allergy/immunology by nearly 1 percent relative to the proposed rule. This increase occurs because we are setting a minimum value of 0.01 malpractice RVUs. In the proposed rule, we did show malpractice RVUs in Addendum B if the rounded RVU equaled 0.0.

The column labeled ''Immunizations/Injections'' shows the impact of making separate payment for injections provided on the same day as another physician fee schedule service and the increase in payment for immunizations. These changes generally benefit those specialties that provide injections and immunizations in their offices. The provision is estimated to increase payment by 2 percent to family practice and by 1 percent to general practice, geriatrics, internal medicine and pediatrics. The column labeled ''Total'' shows the combined percentage change in payments resulting from the practice expense and malpractice RVU changes including those that were described in the proposed rule and the additional changes we are making in this final rule.

As explained in the proposed rule, the practice expense refinements will reduce payments to audiologists by approximately 4 percent. Virtually all of the reduction in payment is due to the refinement of procedure code 92547. We accepted the PEAC recommendation to reduce the clinical staff time of the audiologist involved in this service from 71 minutes to 1 minute. The refinement of clinical staff and equipment resulted in a reduction from 1.15 to 0.08 practice expense RVUs producing the 4 percent reduction in payments shown in table 37. However, this impact assumes no change in how frequently these services are performed. While we received comments suggesting that the code was valued based on only one occurrence of the service, the commenter asserted that it is typically performed more than once per day. Currently, CPT allows it only to be billed once per day. If CPT were to change its policy and the service was billed more frequently, the impact shown in table 37 would be less than shown here.

In the proposed rule, we estimated that payments to vascular surgeons would increase by 3 percent as a result of the repricing of medical equipment used in performing noninvasive vascular diagnostic tests. As indicated above, the total increase in payments including the additional refinements we made to equipment will make the total increase in payment from RVU changes equal to 4 percent. We originally estimated that payments to interventional radiology would increase by 2 percent due practice expense refinements and the establishment of nonfacility pricing for procedure codes 35470 to 35476. Due to additional practice expense RVU refinements, we are now estimating that the total increase in payments will be 3 percent. We are estimating slightly less than a 3.5 percent increase in payment to oral and maxillofacial surgeons from the refinement of medical supplies for procedure codes 21210 and 21215. The estimated impact for this specialty is slightly less than we were estimating for the proposed rule. As we indicated in the proposed rule, the 1 percent decrease in payment to nurse practitioners and geriatricians is

attributed to the refinement of the nonfacility practice expense RVUs for nursing facility visits (procedure codes 99301 through 99316). These impacts are unchanged from the proposed rule.

As we indicated in the proposed rule, the increases for pathology and independent laboratories result from use of a practice expense survey provided by the College of American Pathology (CAP). The increases in the final rule are similar to the figures we estimated for the proposed rule. We further note that independent laboratories receive approximately 20 percent of their total Medicare revenues from physician fee schedule services. The remaining 80 percent of their Medicare revenues are from clinical diagnostic laboratory services that will be unchanged by use of the CAP survey data. Thus, total Medicare revenues to independent laboratories as a result of using the CAP survey will increase by slightly more than 1 percent (or 20 percent of the 6 percent increase in physician fee schedule revenues). There will be little or no impact on all other specialties from use of the CAP survey.

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TABLE 36:
Impact of Practice Expense and Malpractice RVU Changes on Total Medicare Allowed Charges by Physician, Practitioner and Supplier Subcategory

Specialty	Medicare Allowed Charges ($ in Millions)	NPRM Impacts	Additional Practice Expense Refinements	Additional Malpractice RVU Refinements	Injections Immunizations	Total
Physicians:						
ALLERGY/IMMUNOLOGY	$ 161	-2%	0%	1%	0%	-1%
ANESTHESIOLOGY	$ 1,422	0%	0%	0%	0%	0%
CARDIAC SURGERY	$ 359	0%	0%	1%	0%	1%
CARDIOLOGY	$ 6,579	0%	0%	0%	0%	0%
COLON AND RECTAL SURGERY	$ 110	1%	0%	0%	0%	1%
CRITICAL CARE	$ 130	0%	0%	0%	0%	0%
DERMATOLOGY	$ 1,864	1%	0%	-1%	0%	0%
EMERGENCY MEDICINE	$ 1,687	0%	0%	0%	0%	0%
ENDOCRINOLOGY	$ 279	0%	0%	0%	0%	0%
FAMILY PRACTICE	$ 4,456	0%	0%	0%	2%	1%
GASTROENTEROLOGY	$ 1,634	0%	0%	0%	0%	0%
GENERAL PRACTICE	$ 1,003	0%	0%	0%	1%	1%
GENERAL SURGERY	$ 2,264	1%	0%	0%	0%	1%
GERIATRICS	$ 116	-1%	0%	0%	1%	0%
HAND SURGERY	$ 57	0%	0%	0%	0%	0%
INTERNAL MEDICINE	$ 8,784	0%	0%	0%	1%	1%
INTERVENTIONAL RADIOLOGY	$ 191	2%	1%	0%	0%	3%
NEPHROLOGY	$ 747	1%	0%	0%	0%	1%

NEUROLOGY	$	1,197	0%	0%	0%	0%	0%
NEUROSURGERY	$	492	-1%	0%	1%	0%	0%
NUCLEAR MEDICINE	$	85	0%	0%	0%	0%	0%
OPHTHALMOLOGY	$	4,566	-1%	0%	0%	0%	-1%
ORTHOPEDIC SURGERY	$	2,903	0%	0%	0%	0%	0%
OTOLARNGOLOGY	$	814	0%	0%	0%	0%	0%
PATHOLOGY	$	846	2%	0%	0%	0%	2%
PEDIATRICS	$	60	-1%	0%	0%	1%	0%
PHYSICAL MEDICINE	$	680	0%	0%	0%	0%	0%
PLASTIC SURGERY	$	283	1%	0%	0%	0%	0%
PSYCHIATRY	$	1,109	0%	0%	0%	0%	0%
PULMONARY DISEASE	$	1,446	0%	0%	0%	0%	0%
RADIATION ONCOLOGY	$	1,163	0%	0%	0%	0%	0%
RADIOLOGY	$	4,693	0%	0%	0%	0%	0%
THORACIC SURGERY	$	464	0%	0%	0%	0%	1%
VASCULAR SURGERY	$	487	3%	1%	0%	0%	4%
Practitioners:							
AUDIOLOGIST	$	28	-4%	0%	0%	0%	-4%
CHIROPRACTOR	$	658	-1%	0%	0%	0%	-1%
CLINICAL PSYCHOLOGIST	$	494	0%	0%	0%	0%	0%
CLINICAL SOCIAL WORKER	$	317	0%	0%	0%	0%	0%
NURSE ANESTHETIST	$	485	0%	0%	0%	0%	0%
NURSE PRACTITIONER	$	556	-1%	0%	0%	0%	-1%
OPTOMETRY	$	666	0%	0%	0%	0%	0%
ORAL/MAXILLOFACIAL SURGERY	$	36	4%	0%	0%	0%	4%
PHYSICAL/OCCUPATIONAL THERAPY	$	998	-2%	0%	0%	0%	-2%
PHYSICIAN ASSISTANT	$	414	0%	0%	0%	0%	0%
PODIATRY	$	1,392	-1%	0%	1%	0%	1%
Suppliers:							
DIAGNOSTIC TESTING FACILITY	$	879	1%	1%	0%	0%	2%

INDEPENDENT LABORATORY	$	452	6%	0%	0%	0%	6%	0%	1%	0%
PORTABLE X-RAY SUPPLIER	$	92	0%	0%	0%	0%	0%	0%	0%	0%
Other:										
ALL OTHER	$	93	2%	0%	0%	0%	0%	0%	0%	0%
ALL PHYSICIAN FEE SCHEDULE	$	65,803	0%	0%	0%	0%	0%	0%	0%	0%

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As discussed in section II.C of this rule, we are making changes to the malpractice RVUs based on more current malpractice premium data. As anticipated from past revisions to the malpractice RVUs, use of more current malpractice premium data results in minimal impacts on the specialty level payments. The table below shows the impact on total physician fee schedule revenues from the changes to the malpractice RVUs, the additional changes resulting from this final rule and the total impact. See Table 37, ''Impact of Malpractice RVU Changes Proposed Rule and Final Rule'', for a breakdown of the impacts of these revisions on individual specialties. As described above, policies we are adopting in this final rule will increase payments for allergy, neurosurgery and podiatry and decrease payments for dermatology relative to the proposed rule. These changes will also slightly increase payments to cardiac surgery, orthopedic surgery, thoracic surgery and result in a smaller increase in payment for vascular surgery.

Table 37:
Impact Malpractice RVU Changes
Proposed Rule and Final Rule

Specialty	Medicare Allowed Charges ($ in Millions)	NPRM Impacts	Change due to Final Rule	% Change in Total Payment from MP RVU Changes
Physicians:				
ALLERGY/IMMUNOLOGY	$ 161	-0.9%	0.8%	-0.1%
ANESTHESIOLOGY	$ 1,422	0.0%	0.0%	0.1%
CARDIAC SURGERY	$ 359	-0.1%	0.5%	0.4%
CARDIOLOGY	$ 6,579	0.0%	-0.2%	-0.1%
COLON AND RECTAL SURGERY	$ 110	0.6%	0.1%	0.7%
CRITICAL CARE	$ 130	0.5%	-0.2%	0.3%
DERMATOLOGY	$ 1,864	0.7%	-0.9%	-0.2%
EMERGENCY MEDICINE	$ 1,687	0.0%	0.0%	0.0%
ENDOCRINOLOGY	$ 279	0.1%	-0.1%	0.0%
FAMILY PRACTICE	$ 4,456	0.0%	-0.1%	-0.1%
GASTROENTEROLOGY	$ 1,634	0.5%	0.1%	0.6%
GENERAL PRACTICE	$ 1,003	0.0%	-0.1%	-0.1%
GENERAL SURGERY	$ 2,264	0.5%	0.1%	0.6%
GERIATRICS	$ 116	0.3%	-0.2%	0.1%
HAND SURGERY	$ 57	-0.1%	0.1%	0.0%
HEMATOLOGY/ONCOLOGY	$ 1,747	0.0%	-0.1%	0.0%
INFECTIOUS DISEASE	$ 401	0.4%	-0.3%	0.1%
INTERNAL MEDICINE	$ 8,784	0.1%	-0.1%	0.0%
INTERVENTIONAL RADIOLOGY	$ 191	0.0%	0.0%	-0.1%
NEPHROLOGY	$ 747	0.1%	-0.1%	0.0%
NEUROLOGY	$ 1,197	0.2%	-0.1%	0.2%
NEUROSURGERY	$ 492	-0.6%	0.9%	0.3%
NUCLEAR MEDICINE	$ 85	-0.1%	0.0%	-0.1%
OBSTETRICS/GYNECOLOGY	$ 582	0.1%	0.0%	0.1%
OPHTHALMOLOGY	$ 4,566	0.0%	0.0%	0.0%
ORTHOPEDIC SURGERY	$ 2,903	-0.4%	0.4%	0.0%
OTOLARNGOLOGY	$ 814	-0.1%	0.0%	-0.1%
PATHOLOGY	$ 846	0.2%	0.0%	0.2%
PEDIATRICS	$ 60	-0.1%	0.0%	0.0%
PHYSICAL MEDICINE	$ 680	0.2%	-0.1%	0.1%
PLASTIC SURGERY	$ 283	0.6%	-0.5%	0.2%
PSYCHIATRY	$ 1,109	0.3%	-0.3%	0.0%
PULMONARY DISEASE	$ 1,446	0.3%	-0.2%	0.1%
RADIATION ONCOLOGY	$ 1,163	0.0%	0.0%	0.0%
RADIOLOGY	$ 4,693	-0.3%	0.0%	-0.3%
RHEUMATOLOGY	$ 412	-0.1%	0.0%	-0.1%
THORACIC SURGERY	$ 464	0.0%	0.4%	0.4%
UROLOGY	$ 1,695	0.0%	0.0%	-0.1%
VASCULAR SURGERY	$ 487	0.1%	0.2%	0.3%
Practitioners:				
AUDIOLOGIST	$ 28	-0.1%	0.1%	0.0%
CHIROPRACTOR	$ 658	-0.2%	0.0%	-0.2%
CLINICAL PSYCHOLOGIST	$ 494	-0.1%	0.0%	-0.1%
CLINICAL SOCIAL WORKER	$ 317	0.0%	0.0%	0.0%

NURSE ANESTHETIST	$	485	0.0%	0.0%	0.0%
NURSE PRACTITIONER	$	556	0.2%	-0.2%	0.1%
OPTOMETRY	$	666	0.2%	-0.1%	0.1%
ORAL/MAXILLOFACIAL SURGERY	$	36	0.6%	0.0%	0.6%
PHYSICAL/OCCUPATIONAL THERAPY	$	998	-1.3%	-0.1%	-1.4%
PHYSICIAN ASSISTANT	$	414	-0.1%	0.1%	0.1%
PODIATRY	$	1,392	-0.4%	1.1%	0.7%
Suppliers:					
DIAGNOSTIC TESTING FACILITY	$	879	0.0%	0.0%	0.0%
INDEPENDENT LABORATORY	$	452	0.2%	0.0%	0.2%
PORTABLE X-RAY SUPPLIER	$	92	-0.1%	0.0%	-0.1%
Other:					
ALL OTHER	$	93	0.0%	0.0%	0.0%
ALL PHYSICIAN FEE SCHEDULE	$	65,803	0.0%	0.0%	0.0%

Section 1848(d) and (f) of the Act requires the Secretary to set the physician fee schedule update under the sustainable growth rate (SGR) system. For 2004 and 2005, the statute requires the update to be no less than 1.5 percent. Using the statutory formula in section 1848(d)(4) will produce an update of less than 1.5 percent for 2005. Therefore, the physician fee schedule update for 2005 will be 1.5 percent. We have included a complete discussion of our methodology for calculating the SGR and physician fee schedule update in another section of this final rule. Table 38 below shows the estimated change in average payments by specialty resulting from changes to the practice expense and malpractice RVUs and the 2005 physician fee schedule update. (Please note that the table does not include the specialties of Hematology/Oncology, Urology, Rheumatology, Obstetrics/Gynecology and Infectious Disease. There are unique issues related to drug administration that will further affect these specialties that are presented in detail below).

Table 38:

Impact of Practice Expense and Malpractice RVU Changes
and Physician Fee Schedule Update on Total Medicare Allowed Charges
by Physician, Practitioner and Supplier Subcategory

Specialty	Medicare Allowed Charges ($ in Millions)	Practice Expense & Malpractice RVU Changes	Physician Fee Schedule Update	Total
Physicians:				
ALLERGY/IMMUNOLOGY	$ 161	-1%	1.5%	1%
ANESTHESIOLOGY	$ 1,422	0%	1.5%	2%
CARDIAC SURGERY	$ 359	1%	1.5%	2%
CARDIOLOGY	$ 6,579	0%	1.5%	2%
COLON AND RECTAL SURGERY	$ 110	1%	1.5%	2%
CRITICAL CARE	$ 130	0%	1.5%	2%
DERMATOLOGY	$ 1,864	0%	1.5%	2%
EMERGENCY MEDICINE	$ 1,687	0%	1.5%	2%
ENDOCRINOLOGY	$ 279	0%	1.5%	2%
FAMILY PRACTICE	$ 4,456	1%	1.5%	3%
GASTROENTEROLOGY	$ 1,634	0%	1.5%	2%
GENERAL PRACTICE	$ 1,003	1%	1.5%	2%
GENERAL SURGERY	$ 2,264	1%	1.5%	2%
GERIATRICS	$ 116	0%	1.5%	1%
HAND SURGERY	$ 57	0%	1.5%	2%
INTERNAL MEDICINE	$ 8,784	1%	1.5%	2%
INTERVENTIONAL RADIOLOGY	$ 191	3%	1.5%	4%
NEPHROLOGY	$ 747	1%	1.5%	2%
NEUROLOGY	$ 1,197	0%	1.5%	2%
NEUROSURGERY	$ 492	0%	1.5%	2%
NUCLEAR MEDICINE	$ 85	0%	1.5%	2%
OPHTHALMOLOGY	$ 4,566	-1%	1.5%	0%
ORTHOPEDIC SURGERY	$ 2,903	0%	1.5%	1%
OTOLARNGOLOGY	$ 814	0%	1.5%	2%
PATHOLOGY	$ 846	2%	1.5%	4%

PEDIATRICS	$	60	0%	1.5%	2%
PHYSICAL MEDICINE	$	680	0%	1.5%	1%
PLASTIC SURGERY	$	283	0%	1.5%	2%
PSYCHIATRY	$	1,109	0%	1.5%	1%
PULMONARY DISEASE	$	1,446	0%	1.5%	2%
RADIATION ONCOLOGY	$	1,163	0%	1.5%	1%
RADIOLOGY	$	4,693	0%	1.5%	2%
THORACIC SURGERY	$	464	1%	1.5%	2%
VASCULAR SURGERY	$	487	4%	1.5%	6%
Practitioners:					
AUDIOLOGIST	$	28	-4%	1.5%	-2%
CHIROPRACTOR	$	658	-1%	1.5%	1%
CLINICAL PSYCHOLOGIST	$	494	0%	1.5%	1%
CLINICAL SOCIAL WORKER	$	317	0%	1.5%	1%
NURSE ANESTHETIST	$	485	0%	1.5%	2%
NURSE PRACTITIONER	$	556	-1%	1.5%	0%
OPTOMETRY	$	666	0%	1.5%	1%
ORAL/MAXILLOFACIAL SURGERY	$	36	4%	1.5%	5%
PHYSICAL/OCCUPATIONAL THERAPY	$	998	-2%	1.5%	-1%
PHYSICIAN ASSISTANT	$	414	0%	1.5%	1%
PODIATRY	$	1,392	1%	1.5%	2%
Suppliers:					
DIAGNOSTIC TESTING FACILITY	$	879	2%	1.5%	3%
INDEPENDENT LABORATORY	$	452	6%	1.5%	8%
PORTABLE X-RAY SUPPLIER	$	92	0%	1.5%	1%
Other:					
ALL OTHER	$	93	1%	1.5%	3%
ALL PHYSICIAN FEE SCHEDULE	$	65,803	0%	1.5%	2%

Table 39 shows the impact on payments for selected high-volume procedures of all of the changes previously discussed. We selected these procedures because they are the most commonly provided procedures by a broad spectrum of physician specialties, or they are of particular interest to the physician community (for example, the initial preventive physical exam and EKG, codes G0344, G0366, G0367 and G0368). We note that the table below shows Medicare payment for the administration of an influenza vaccine, G0008, increasing from $8.21 to $18.57, or 126 percent. As explained earlier, we are establishing the same RVUs for the administration of a vaccine and an injection. For 2005 only, we will pay 3 percent more for the injection ($19.13) because of the transitional adjustment required by section 303. After 2005, the payment for the administration of a vaccine and an injection will be the same. This table shows the combined impact of the change in the practice expense and malpractice RVUs and the estimated physician fee schedule update on total payment for the procedure. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility practice expense RVUs refer to § 414.22(b)(5)(i). The table shows the estimated change in payment rates based on provisions of this final rule and the estimated physician fee schedule update.

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Table 39:

Impact of Final Rule and Physician Fee Schedule Update
on Medicare Payment for Selected Procedures

			Non-Facility			Facility		
CODE	MOD	DESCRIPTION	Old	New	% Change	Old	New	% Change
11721		Debride nail, 6 or more	$ 38.08	$ 38.66	2%	$ 29.87	$ 29.94	0%
17000		Destroy benign/premlg lesion	$ 60.49	$ 61.39	1%	$ 35.84	$ 45.10	26%
27130		Total hip arthroplasty	N/A	N/A	N/A	$1,370.28	$1,383.26	1%
27244		Treat thigh fracture	N/A	N/A	N/A	$1,115.27	$1,128.97	1%
27447		Total knee arthroplasty	N/A	N/A	N/A	$1,475.95	$1,493.16	1%
33533		CABG, arterial, single	N/A	N/A	N/A	$1,882.18	$1,905.49	1%
35301		Rechanneling of artery	N/A	N/A	N/A	$1,114.89	$1,122.52	1%
43239		Upper GI endoscopy, biopsy	$321.85	$333.88	4%	$ 159.43	$ 162.58	2%
66821		After cataract laser surgery	$240.83	$248.23	3%	$ 237.09	$ 230.42	-3%
66984		Cataract surg w/iol, 1 stage	N/A	N/A	N/A	$ 684.39	$ 684.05	0%
67210		Treatment of retinal lesion	$577.98	$599.54	4%	$ 560.81	$ 573.39	2%
71010	26	Chest x-ray	$ 9.33	$ 9.47	2%	$ 9.33	$ 9.47	2%
76091	26	Mammogram, both breasts	$ 44.80	$ 45.10	1%	$ 44.80	$ 45.10	1%
76091		Mammogram, both breasts	$ 96.33	$ 97.40	1%	N/A	N/A	N/A
76092	26	Mammogram, screening	$ 36.22	$ 36.38	0%	$ 36.22	$ 36.38	0%
76092		Mammogram, screening	$ 84.76	$ 85.65	1%	N/A	N/A	N/A
77427		Radiation tx management, x5	$169.14	$172.05	2%	$ 169.14	$ 172.05	2%
78465	26	Heart image (3d), multiple	$ 76.17	$ 77.31	1%	$ 76.17	$ 77.31	1%
88305	26	Tissue exam by pathologist	$ 41.44	$ 42.07	2%	$ 41.44	$ 42.07	2%
90801		Psy dx interview	$150.84	$153.48	2%	$ 142.26	$ 144.39	1%
90862		Medication management	$ 51.15	$ 52.30	2%	$ 48.17	$ 49.27	2%
90935		Hemodialysis, one evaluation	N/A	N/A	N/A	$ 72.06	$ 73.14	1%
92012		Eye exam established pat	$ 63.47	$ 65.18	3%	$ 36.22	$ 37.14	3%
92014		Eye exam & treatment	$ 93.34	$ 96.26	3%	$ 58.99	$ 60.64	3%
92980		Insert intracoronary stent	N/A	N/A	N/A	$ 812.09	$ 830.33	2%
93000		Electrocardiogram, complete	$ 26.51	$ 27.29	3%	N/A	N/A	N/A
93010		Electrocardiogram report	$ 8.96	$ 9.10	2%	$ 8.96	$ 9.10	2%
93015		Cardiovascular stress test	$106.78	$108.39	2%	N/A	N/A	N/A
93307	26	Echo exam of heart	$ 49.29	$ 49.27	0%	$ 49.29	$ 49.27	0%
93510	26	Left heart catheterization	$252.77	$257.32	2%	$ 252.77	$ 257.32	2%
98941		Chiropractic manipulation	$ 36.22	$ 36.76	1%	$ 31.74	$ 31.83	0%
99203		Office/outpatient visit, new	$ 95.96	$ 97.02	1%	$ 71.69	$ 72.38	1%
99213		Office/outpatient visit, est	$ 52.65	$ 52.68	0%	$ 35.47	$ 35.62	0%
99214		Office/outpatient visit, est	$ 82.14	$ 82.62	1%	$ 57.87	$ 59.12	2%

99222	Initial hospital care	N/A	N/A	N/A	$ 111.27	$ 112.93	1%
99223	Initial hospital care	N/A	N/A	N/A	$ 154.95	$ 157.27	1%
99232	Subsequent hospital care	N/A	N/A	N/A	$ 54.89	$ 56.09	2%
99233	Subsequent hospital care	N/A	N/A	N/A	$ 78.04	$ 79.58	2%
99236	Observ/hosp same date	N/A	N/A	N/A	$ 226.26	$ 223.60	-1%
99239	Hospital discharge day	N/A	N/A	N/A	$ 95.21	$ 96.64	2%
99243	Office consultation	$120.60	$122.79	2%	$ 92.22	$ 93.99	2%
99244	Office consultation	$170.63	$172.81	1%	$ 136.65	$ 138.70	2%
99253	Initial inpatient consult	N/A	N/A	N/A	$ 97.45	$ 98.91	1%
99254	Initial inpatient consult	N/A	N/A	N/A	$ 140.39	$ 142.12	1%
99261	Follow-up inpatient consult	N/A	N/A	N/A	$ 22.40	$ 22.36	0%
99262	Follow-up inpatient consult	N/A	N/A	N/A	$ 44.80	$ 45.48	2%
99263	Follow-up inpatient consult	N/A	N/A	N/A	$ 66.09	$ 67.46	2%
99283	Emergency dept visit	N/A	N/A	N/A	$ 61.61	$ 62.15	1%
99284	Emergency dept visit	N/A	N/A	N/A	$ 95.58	$ 97.02	2%
99291	Critical care, first hour	$242.69	$256.57	6%	$ 203.12	$ 207.68	2%
99292	Critical care, addÏl 30 min	$107.91	$114.07	6%	$ 101.56	$ 104.22	3%
99302	Nursing facility care	$ 97.82	$ 87.92	-10%	$ 82.52	$ 87.92	7%
99303	Nursing facility care	$120.97	$108.39	-10%	$ 102.68	$ 108.39	6%
99312	Nursing fac care, subseq	$ 63.10	$ 56.85	-10%	$ 51.53	$ 56.85	10%
99313	Nursing fac care, subseq	$ 86.25	$ 79.96	-7%	$ 72.43	$ 79.96	10%
99348	Home visit, est patient	$ 75.42	$ 72.01	-5%	N/A	$ 68.22	N/A
99350	Home visit, est patient	$169.89	$165.23	-3%	N/A	$ 160.31	N/A
G0008	Admin influenza virus vac	$ 8.21	$ 18.57	126%	N/A	N/A	N/A
G0317	ESRDrelsvc 4+/mo;20+yr	$303.18	$307.73	2%	$ 303.18	$ 307.73	2%
G0344	Initial preventive exam	N/A	$ 97.40	N/A	N/A	$ 72.76	N/A
G0366	EKG for initial prevent exam	N/A	$ 27.29	N/A	N/A	N/A	N/A
G0367	EKG tracing for initial prev	N/A	$ 17.81	N/A	N/A	N/A	N/A
G0368	EKG interpret & report preve	N/A	$ 9.10	N/A	N/A	$ 9.10	N/A

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Section 303(a)(1) of the MMA amended section 1848(c)(2) of the Act to require increased work and practice expense RVUs for drug administration services. Section 303(a)(4) of the MMA required an additional temporary increase in payment to specific drug administration services of 32 percent for 2004 and 3 percent for 2005. Table 41 shows the payment amounts for selected high-volume drug administration CPT codes from 2002 to 2006 including the effect of the transition adjustment of 32 percent required for 2004 and 3 percent for 2005. Because we may also pay an additional $130 per encounter under the national demonstration project in 2005, we are also including the effect of this additional payment where applicable. Table 42 that follows table 41 shows the payment amount for 2004 and 2005 without the additional transition adjustment required by the MMA and national demonstration payment amount. By showing the payment amounts without the transition and demonstration, we can isolate the permanent change in the payment amounts that is occurring as a result of the MMA, the CPT/RUC review and the physician fee schedule update. The amounts shown in the table include the effect of the 1.5 percent update for 2004 and 2005. As described above, the CPT and RUC have recommended changes to the coding and payment for drug administration services. The CPT/RUC review was undertaken at our request under the authority of section 1848(c)(2)(J) of the Act that requires the Secretary to promptly evaluate existing drug administration codes using existing processes. While this review was completed expeditiously, CPT did not have sufficient time to adopt the coding recommendations into the 2005 version of CPT. For this reason, we are establishing new G-codes for 2005 that correspond with the new CPT codes that will become active in 2006.

Tables 41 and 42 show the payment amounts for the most frequently performed drug administration services from 2002 to 2004 under the CPT codes and payment for the comparable service in 2005 using the G code. For instance, a therapeutic injection was previously billed under the CPT code 90782. This same service will now be billed using HCPCS code G0351. As a result of the RUC review, our acceptance of their recommendations for refinements to the practice expense inputs, our policy of pooling the utilization for the injection with vaccine administration, and the required reduction in the transitional adjustment, payment for this service will be reduced from $24.64 in 2004 to $19.13 in 2005. However, the 2004 transition adjustment largely accounts for the decline. If the transitional adjustment of 32 percent for 2004 and 3 percent for 2005 were not applied, payment for the injection would be virtually the same in 2005 as in 2004, a decline of $0.10 from $18.67 to $18.57. This table shows the permanent large increase in payment for this code from 2002 to 2005. The payment for a therapeutic injection increased from $3.98 in 2002 to $19.13 in 2005, a 381

percent increase (or $18.57 if the transitional adjustment were not applied, a 367 percent increase).

CPT is also recommending separate codes for the administration of hormonal anti-neoplastic subcutaneous/intramuscular (SC/IM) injections from other anti-neoplastic injections. Under the current CPT codes, all anti-neoplastics administered SC/IM are billed using CPT code 96400. HCPCS code G0356 will be used for the administration of hormonal anti-neoplastic injections. CPT code 96400 is currently paid $64.07. Its comparable code for 2005 (G0356) will be paid $36.69 or a reduction of 43 percent. Without the transition, payment for the code would have been reduced from $48.54 to $35.62 or 27 percent between 2004 and 2005. However, payment for this code increased from $5.07 to $35.62 (without the transition) between 2002 and 2005 or by 603 percent.

There is currently one CPT code for anti-neoplastic drugs administered by intravenous (IV) push (96408). In 2004, physicians are receiving $154.76 for CPT code 96408. Payment in 2005 for G0351 (the comparable code) will be $125.69. In addition, Medicare may also pay an additional $130.00 per encounter under the demonstration increasing the total payment to $255.69 or an increase of 65 percent between 2004 and 2005. Without the transitional adjustments or the demonstration, payment for this service would have increased from $117.24 in 2004 to $122.03 in 2003 or by 4 percent. From 2002 to 2005, payment will have increased from $35.11 to $122.03 (without the transition), or a 248 percent increase.

CPT will be creating new codes that distinguish between the first and subsequent administration of a drug by IV push to the same patient on the same day. The RUC is recommending fewer inputs for the subsequent administration of a drug by IV push than the initial drug. We are creating code G0358 for each subsequent drug administered by IV push for 2005. Before the enactment of the MMA, Medicare allowed CPT code 96408 to be paid only once per patient per day. However, as a result of the MMA, we changed our policy and allowed physicians to bill and be paid for more than one administration of a chemotherapy drug by IV push to the same patient on a single day (see 69 FR 1094–1095). Thus, because separate codes do not currently exist for the multiple administrations of chemotherapy drugs by IV push on a single day, physicians currently are paid at the rate for 96408 (or $154.76) for each subsequent administration. Using the CPT's and RUC recommendations, we will pay $72.99 for subsequent drugs administered by IV push using HCPCS code G0358. While the payment is less in 2005 and 2004, payment remains higher in 2005 than in 2003 and prior years when Medicare provided no payment for the subsequent administration of a drug by IV push.

We are creating HCPCS codes G0359 and G0360 for the initial and subsequent hour respectively of chemotherapy drugs administered by IV infusion. As described in the drug administration section, CPT has changed its definition of chemotherapy to include infusion of substances such as monoclonal antibody agents or other biologic response modifiers in addition to anti-neoplastic drugs. Thus, services previously billed under the CPT code 90780 (initial hour) and 90781 (each additional hour) that meet this new definition of chemotherapy will now be billed under CPT code G0359 (initial hour) and G0360 (each additional hour). Payment for the infusion of substances such as monoclonal antibody agents or other biologic response modifiers paid under CPT code 90780 will be increasing from $117.79 in 2004 to $177.61 in 2005 using HCPCS code G0359, a 51 percent increase. Without including the transition adjustment, payment for these services will have increased by 93 percent from $89.24 in 2004 to $172.43 in 2005 or by 325 percent from the 2002 rate of $40.54. Payment for the subsequent hour infusion under CPT code 90781 will increase from $33.02 in 2004 to $40.21 in 2005 under HCPCS code G0360 or by 22 percent. Without including the transition adjustment, payment for the subsequent hour infusion will have increased 56 percent from $25.02 in 2004 to $39.03 in 2005 or 93 percent from its 2002 rate of $20.27.

Anti-neoplastic agents that were previously billed under CPT code 96410 (initial hour) and 96412 (each additional hour) will also be billed under codes G0359 and G0360. We have listed codes G0359 and G0360 twice to reflect that Medicare payment for each respective code is paid under two different CPT codes for services rendered prior to January 1, 2005. Payment for the initial hour of an anti-neoplastic agent administered by infusion under CPT code 96410 will be going from $217.35 in 2004 to $177.61 in 2005. Including the $130.00 per encounter demonstration payment in this amount brings the total payment to $307.61, an increase of 65 percent. Without including the transition adjustment, payment for these services will have increased by 5 percent from $164.66 in 2004 to $172.43 in 2005 or by 209 percent from the 2002 rate of $55.75. Payment for the subsequent hour infusion under CPT code 96412 will decrease from $48.30 in 2004 to $40.21 in 2005 under HCPCS code G0360 or by 17 percent. Without including the transition adjustment, payment for the subsequent hour infusion will have increased 7 percent from $36.59 in 2004 to $39.03 in 2005. Payment for the subsequent hour infusion of an anti-neoplastic agent has been reduced by 6 percent from its 2002 rate of $41.63. The reduction in payment is occurring because resource-based pricing replaced the use of charge-based RVUs when the services were removed from the nonphysician work pool in 2004.

The CPT is also recommending a new code for the initial hour of a subsequent chemotherapy drug administered by infusion. The new code would recognize that there are higher resources associated with the first hour of infusion of a subsequent drug than there are in the subsequent hour of the initial drug. Under current CPT coding, the first hour of a subsequent drug administered by IV infusion is paid under CPT code 96412. In 2004, Medicare pays $48.30 for this service. In 2005, we will pay $86.66 or 79 percent more for HCPCS code G0362 that will be used for the initial hour of a subsequent drug administered by IV infusion. Without including the transition adjustment, payment for this service will have increased 130 percent from $36.59 in 2004 to $84.13 in 2005 or 102 percent from the 2002 rate of $41.63.

The volume-weighted average permanent increase in payment among all drug administration services is approximately 117 percent from 2003 to 2005 including the effect of the CPT/RUC recommendations but excluding the effect of the transition adjustment. Including the effect of the transition (but not the demonstration payment) makes the volume-weighted increase in payment for these codes more than 120 percent from 2003 to 2005.

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Table 40:

Impact of Final Rule and Physician Fee Schedule Update
on Medicare Payment for Selected Drug Administration Services
Including the Effect of the 32 and 3% Transition Adjustments and Demonstration Project

Old Code	New Code	Description	2002 Payment	2003 Payment	2004 Payment with Transition	2005 Payment with Transition	2005 Demo Payment*	2005 w/Transition and Demo	% Change 04 to 05
90782	G0351	Therapeutic/diagnostic injec	$ 3.98	$ 4.41	$ 24.64	$ 19.13	N/A	$ 19.13	-22%
96400	G0356	Hormonal anti-neoplastic	$ 5.07	$ 37.52	$ 64.07	$ 36.69	N/A	$ 36.69	-43%
96408	G0357	IV push single/initial subst	$ 35.11	$ 37.52	$ 154.76	$ 125.69	$130.00	$ 255.69	65%
N/A	G0358	IV push each additional drug	N/A	N/A	$ 154.76	$ 72.99	N/A	$ 72.99	-53%
96410	G0359	Chemotherapy IV one hr initi	$ 55.75	$ 59.22	$ 217.35	$ 177.61	$130.00	$ 307.61	42%
90780	G0359	Chemotherapy IV one hr initi	$ 40.54	$ 42.67	$ 117.79	$ 177.61	N/A	$ 177.61	51%
96412	G0360	Each additional hr 1-8 hrs	$ 41.63	$ 44.14	$ 48.30	$ 40.21	N/A	$ 40.21	-17%
90781	G0360	Each additional hr 1-8 hrs	$ 20.27	$ 21.70	$ 33.02	$ 40.21	N/A	$ 40.21	22%
96412	G0362	Each add sequential infusion	$ 41.63	$ 44.14	$ 48.30	$ 86.66	N/A	$ 86.66	79%

- The demonstration payments will only be made once per day per patient with a diagnosis of cancer. Thus, we are only showing them as an additional payment to an initial drug administration service when an anti-neoplastic agent is administered.

Table 41:

Impact of Proposed Rule and Physician Fee Schedule Update on Medicare Payment for Selected Drug Administration Services Excluding the Effect of the 32 and 3% Transition Adjustments and Demonstration Project

Old Code	New Code	Description	2002 Payment	2003 Payment	2004 Payment without Transition	2005 Payment without Transition
90782	G0351	Therapeutic/diagnostic injec	$ 3.98	$ 4.41	$ 18.67	$ 18.57
96400	G0356	Hormonal anti-neoplastic	$ 5.07	$ 37.52	$ 48.54	$ 35.62
96408	G0357	IV push single/initial subst	$ 35.11	$ 37.52	$ 117.24	$ 122.03
N/A	G0358	IV push each additional drug	N/A	N/A	$ 117.24	$ 70.87
96410	G0359	Chemotherapy IV one hr initi	$ 55.75	$ 59.22	$ 164.66	$ 172.43
90780	G0359	Chemotherapy IV one hr initi	$ 40.54	$ 42.67	$ 89.24	$ 172.43
96412	G0360	Each additional hr 1-8 hrs	$ 41.63	$ 44.14	$ 36.59	$ 39.03
90781	G0360	Each additional hr 1-8 hrs	$ 20.27	$ 21.70	$ 25.02	$ 39.03
96412	G0362	Each add sequential infusion	$ 41.63	$ 44.14	$ 36.59	$ 84.13

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Table 42 below shows the impact of physician fee schedule changes for selected specialties that receive a significant portion of their total Medicare revenues from drugs. Table 43 that follows table 42 shows the combined impact of the physician fee schedule and drug payment changes on total Medicare revenues. Our estimates of changes in Medicare revenues for drugs and physician fee schedule services compare payment rates for 2005 with payment rates for 2004 using 2003 Medicare utilization for both years. For physician fee schedule services, we mapped the 2003 Medicare utilization to the code set in use for 2005 based on assumptions about how the new drug administration codes will be billed. These assumptions are based on our consultations with the American Society of Clinical Oncology and other physician specialty societies that participated in the CPT's Drug Administration workgroup. We are using 2003 Medicare claims processed and paid through June 30, 2004 that we

estimate are 98.5 complete and have adjusted the figures to reflect a full year of data. Thus, because we are using a single year of utilization, the estimated changes in revenues reflect payment changes only between 2004 and 2005. To the extent that there are year-to-year changes in the volume and mix of drugs and physician fee schedule services provided by physicians, the actual impact on total Medicare revenues will be different than those shown here.

The column labeled ''NPRM Impacts'' shows the impact of the practice expense and malpractice RVU changes described earlier. The refinements of the practice expense RVUs and 5-year review of malpractice will have little or no impact on physician fee schedule payments for the 5 specialties shown. The column labeled ''Coding and RVU Changes'' shows the impact of our adoption of the CPT/RUC recommended revisions to the codes and payment amount for drug administration services. We estimate that the changes from the CPT/RUC process will increase physician fee schedule payments for oncologists by 5 percent. This impact is generally attributable to higher permanent increases in payment for the administration of drugs by IV push (G0357), infusion (G0359 and G0360) and the ability to be paid at a higher rate for the initial hour of infusion of a subsequent drug administered. We estimate that the changes from the CPT/RUC process will increase payments to rheumatologists by 4 percent. This impact is due to the change in the definition of the chemotherapy that will allow rheumatologists to bill substances such as monoclonal antibody agents or other biologic response modifiers using the chemotherapy administration codes. The CPT/RUC changes will have little or no specialty level impact on other specialties that administer drugs.

The next column shows the effect of the drug administration transition on Medicare physician fee schedule revenues for the specialties shown. As explained earlier, section 303(a)(4) requires that the transition adjustment percentage be reduced from 32 percent in 2004 to 3 percent in 2005. The change to the transition payment percentage will reduce payments for the specialties that provide drug administration services. The reduction has a larger impact on oncologists than the other physician specialties shown because drug administration services represent a larger proportion of their physician fee schedule revenues.

The column labeled ''Additional Payments for Injections'' shows the effect of paying for injections (as well as non-chemotherapy drugs administered by IV push) provided on the same day as other physician fee schedule services. We estimate that this policy change will increase payment an estimated 3 percent for oncologists and 1 percent for other specialties. This policy change will also modestly increase payment to other specialties that provide injections (primarily family practitioners and internists) and has been incorporated into the earlier impact tables.

The next column shows the impact of the 1.5 percent physician fee schedule update. The column labeled ''One-Year Demonstration Project'' shows the impact of our plan to establish a national demonstration project that will pay oncologists $130 for providing specific services to their patients and reporting patient quality data. If oncologists participate in this demonstration project and provide the required services and requested information, we estimate that their payments will increase by 15 percent. Taken together, we estimate that the coding and RVU changes, the change to the transition amount for drug administration, the additional payments for injections, the physician fee schedule update and the national demonstration project will increase physician fee schedule payments to oncologists by 10 percent. The combined impact of these factors (other than the national demonstration project) will increase physician fee schedule payments by 1 percent urologists, 5 percent for rheumatologists, 1 percent for obstetrics/gynecologists and 0 percent for infectious disease.

Table 43 shows the combined impact of changes we are making to Medicare drug and physician fee schedule payments for the same specialties shown in table 42. The payment impacts for drugs are based on the 2nd quarter ASP submissions from drug manufacturer's and reflect ¾ of an annualized increase in drug prices between the 2nd quarter of 2004 and the 1st quarter of 2005 of 3.39 percent or 2.54 percent. The drug payment impacts are based on ASP prices for drugs accounting for approximately 94 percent of Medicare's total drug payments. Of Medicare's total payments for drugs, at least 4 percent are paid under ''not otherwise classified (NOC)'' codes (*i.e.* J3490 and J0999). Thus, we based our impacts on ASP prices for drugs accounting for approximately 98 percent of Medicare revenues that are not in the NOC category.

The column labeled ''% of Total Medicare Revenues from Fee Schedule'' shows the proportion of total Medicare revenues received from physician fee schedule services. The following column shows the physician fee schedule payment impact. All of the payment impacts are the same as those shown in Table 43. The following column shows the proportion of total Medicare revenues received from drugs, while the next column shows the payment impact from adoption of the ASP drug payment methodology. The next 3 columns show combined Medicare revenues from all sources and the combined Medicare payment impact from the earlier described changes being adopted for 2005.

Our estimates of changes in Medicare revenues for both drugs and drug administration services compare payment rates for 2005 with payment rates for 2004 using the same utilization in both years. We used 2003 utilization for these comparative impacts since they are the latest data available. Thus, the estimated changes in revenues reflect *purely* price changes between 2004 and 2005. We note that these impacts and percentages represent averages for each specialty or supplier. The percentages and impacts for any individual physician are dependent on the mix of drugs and physician fee schedule services they provide to Medicare beneficiaries. For this analysis, we are also supplementing the data showing the change in revenues with volume growth based on historical trends.

As indicated in Table 43, physician fee schedule services account for approximately 28 percent of oncology's 2004 Medicare revenues. The changes we are adopting in this final rule are estimated to increase Medicare payments for physician fee schedule services by 10 percent from 2004 to 2005. We estimate that approximately 69 percent of total 2004 Medicare revenues for oncologists are attributed to drugs and the adoption of the ASP pricing methodology will reduce these revenues by 13 percent. We based our analysis on drugs accounting for approximately 92 percent of total oncology drug revenues (and 99 percent of oncology drug revenues not paid under NOC codes). The actual impact on oncologists' total Medicare revenues will be different from these estimated impacts to the extent that utilization of drugs and drug administration services does increase. In recent years, increasing utilization, for example, drug spending growth in excess of 20 percent per year, has occurred. The weighted average of the drug and physician fee schedule changes assuming no change in utilization would decrease Medicare revenues to oncology by 6 percent. However, if the volume of drugs and physician fee schedule services

increased at historical rates, total Medicare revenues for oncologists are estimated to increase by 4 percent between 2004 and 2005, excluding the demonstration project. If we include the demonstration project, Medicare revenues to oncologists are estimated to increase by 8 percent between 2004 and 2005. We note that our actuaries' estimates of section 303 with the drug prices and policy changes in this final rule match earlier estimates of the FY 2005 and 10-year savings figures.

We estimate that urology receives approximately 57 percent of their 2004 total revenues from physician fee schedule services and 35 percent from drugs. We estimate that physician fee schedule revenues for urologists will increase by approximately 1 percent from 2004 to 2005. Based on ASP prices for drugs accounting for 100 percent of urologists' drug revenues, we estimate a 40 percent reduction assuming no growth in the volume of services provided. In this scenario, combined Medicare payments to urologists would decline approximately 14 percent. However, if the volume of physician fee schedule services and drugs were to grow at historical rates, we estimate that Medicare revenues to urologists would decline by 8 percent.

We estimate that physician fee schedule revenues account for approximately 49 percent of rheumatology's total revenues. Drugs account for approximately 44 percent rheumatology's total revenues. Physician fee schedule revenues are estimated to increase 5 percent for rheumatology and revenues from drugs are estimated to decline by 8 percent. Assuming no growth in utilization, the combined reduction in rheumatologists' revenues would be 1 percent. If the volume of drugs and physician fee schedule services grew at historical rates, rheumatologists' revenues from Medicare would increase by 9 percent.

We estimate that physician fee schedule revenues account for approximately 87 percent of total revenues for obstetrics/gynecology. These revenues are anticipated to increase by 1 percent. Drug revenues represent 13 percent of total Medicare revenues for obstetrics/gynecology and are estimated to decline by 21 percent. Assuming no growth in utilization, we estimated that obstetrics/gynecology's combined Medicare revenues would decline by 2 percent. Using the historical projected rates of growth for the volume of drugs and physician fee schedule services would make the estimated change in revenues equal an increase of 4 percent.

We estimate that physician fee schedule revenues account for approximately 94 percent of total revenues for infectious disease physicians. These payments are not estimated to change. The remainder of Medicare revenues for infectious disease physicians can be attributed to drugs. These payments are expected to decline by 25 percent. The weighted average change in infectious disease revenues from the changes we are adopting in this final rule is -2 percent assuming no growth in the volume of drugs and physician fee schedule services. If future growth in the volume of drugs and physician fee schedule services were to grow at historical rates, revenues to infectious disease physicians would increase would increase 7 percent.

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Table 42:

Impact of Drug and Physician Fee Schedule Payment Changes
on Total Medicare Allowed Charges
for Selected Specialties

		Physician Fee Schedule						
Specialty	Medicare Allowed Charges ($ in Millions)	NPRM Impacts	Coding and RVU Changes	Drug Administration Transition	Additional Payments for Injections	Physician Fee Schedule Update	One-Year Demonstration Project	Total
HEMATOLOGY/ONCOLOGY	$ 1,747	0%	5%	-12%	3%	1.5%	15%	10%
UROLOGY	$ 1,695	0%	0%	-1%	0%	1.5%	N/A	1%
RHEUMATOLOGY	$ 582	0%	4%	-2%	1%	1.5%	N/A	5%
OBSTETRICS/GYNECOLOGY	$ 412	0%	0%	-1%	0%	1.5%	N/A	1%
INFECTIOUS DISEASE	$ 401	0%	0%	-1%	0%	1.5%	N/A	0%

Table 43:
Combined Payment Impact
Drug and Physician Fee Schedule Payment Changes
for Selected Specialties

	Physician Fee Schedule		Drugs			All Revenues			
Specialty	% of Total Medicare Revenues from Fee Schedule	% Change Medicare Physician Fee Schedule Revenues	% of Total Medicare Revenues from Drugs	% Change Medicare Drug Revenues	Combined Medicare Revenues All Sources ($ in Millions)	Combined % Change All Medicare Revenues Constant Utilization	Combined % Change All Medicare Revenues** w/Utilization Growth
HEMATOLOGY/ONCOLOGY	28%	10%	69%	-13%	$ 6,346	-6%	8%
UROLOGY	57%	1%	35%	-40%	$ 2,967	-14%	-8%
RHEUMATOLOGY	49%	5%	44%	-8%	$ 844	-1%	16%
OBSTETRICS/GYNECOLOGY	87%	1%	13%	-21%	$ 667	-2%	5%
INFECTIOUS DISEASE	94%	0%	6%	-25%	$ 428	-2%	7%

** Note: We estimate that Medicare payments to oncologists would increase by 8% between 2004 and 2005 if growth in the volume of drugs and physician fee schedule services were to continue growing at historical rates and the effect of the demonstration project was included. Revenue projections including price and volume changes for the other specialties are shown as well.

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B. Geographic Practice Cost Indices

As discussed in section II.B, in this rule, we are proposing changes to the work and practice expense GPCIs based on new census data. The resulting geographic redistributions would not result in an overall increase in the current geographic adjustment indices by more than 3.5 percent or a decrease by more than 1.6 percent for any given locality in 2005. These geographic redistributions would not result in an overall increase in the current geographic adjustment indices by more than 7 percent or a decrease by more than 3.5 percent for any given locality in 2006. Addenda F and G illustrate the

locality specific overall impact of this proposal. The GAF, as displayed in Addenda F and G is a weighted composite index of the individual revisions to the work, practice expense, and malpractice expense GPCIs, respectively. The malpractice GPCI was updated as part of the November 7, 2003 final rule, and the MMA provisions were addressed in the final rule published on January 7, 2004.

C. Coding Issues

1. Additions to the List of Medicare Telehealth Services

In section II.D, we are adding end stage renal disease (ESRD) services, as represented by HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, G03178 to the list of telehealth services. We believe that this change will have little effect on Medicare expenditures.

2. National Pricing of G0238/G0239 (Respiratory Therapy Service Codes)

As discussed earlier in the preamble, we are using the nonphysician workpool to value two respiratory therapy service codes (G0238 and G0239) that are currently carrier priced. We believe that this change will eliminate the uncertainty surrounding payment of these codes when performed in comprehensive outpatient rehabilitation facilities that are paid under the physician fee schedule through fiscal intermediaries. We do not anticipate that nationally pricing these services will have a significant impact on Medicare expenditures.

3. New HCPCS Code for Bone Marrow Aspiration

We are implementing a new HCPCS add-on code, GO367 for instances when a bone marrow aspiration and a bone marrow biopsy are performed on the same day through a single incision. While this coding change will allow for a small additional payment for the second procedure performed through a single incision on the same day, we anticipate that the costs will be insignificant.

4. New HCPCS Code for Venous Mapping

As stated earlier in the preamble, we are implementing a new HCPCS code G0365, for mapping of vessels for hemodialysis access. Payment for this code will be crosswalked by CPT code 93990, Doppler Flow Testing. We anticipate that the costs of this change will be minor and may result in improved care to Medicare beneficiaries and less long-term costs to Medicare.

D. MMA Provisions

1. Section 611—Preventive Physical Examination

As discussed earlier in this preamble, the MMA authorizes coverage of an initial preventive physical examination effective January 1, 2005, subject to certain eligibility and other limitations. This new benefit will result in an increase in Medicare expenditures for new payments made to physicians and other practitioners who provide these examinations and for any medically necessary follow-up tests, counseling, or treatment that may be required as a result of the coverage of these examinations. The impact of this provision is shown in the following table.

TABLE 44:
Medicare Cost Estimates for MMA Provision 611
(in millions)

MMA provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 611	$40	$40	$40	$40	$40

2. Section 613—Diabetes Screening

Section 613 of the MMA adds subsection (yy) to section 1861 of the Social Security Act and mandates coverage of diabetes screening tests, effective on or after January 1, 2005. We expect that this change in coverage for certain beneficiaries will result in an increase in Medicare payments. These payments will be made to physicians' office laboratories and other laboratory suppliers who perform these tests as a result of the increased frequency of coverage of these tests. The impact of this provision is shown in Table 45 that follows.

3. Section 612—Cardiovascular Screening

Section 612 of the MMA provides for Medicare coverage for cholesterol and other lipid or triglyceride levels of cardiovascular screening blood tests for the early detection of abnormalities associated with an elevated risk for such diseases effective on or after January 1, 2005. We estimate that this change in coverage for certain beneficiaries will result in an increase in Medicare payments. These payments will be made to physician office laboratories and other laboratory suppliers who perform these tests as a result of the increased frequency of coverage of these tests. Increased Medicare program expenditures for this provision are shown in Table 45 below.

TABLE 45:
Medicare Cost Estimates for MMA Provisions 612 and 613
(in millions)

MMA Provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 612 Cholesterol and Blood Lipid	50	80	90	90	100
Sec. 613 Diabetes Screening	20	40	50	60	80

4. Section 413—Incentive Payment for Physician Scarcity

a. Physician Scarcity Areas

Section 413(a) of the MMA provides a new 5-percent incentive payment to physicians who furnish services in physician scarcity areas. The MMA provides for paying primary care physicians furnishing services in a primary care scarcity area, and specialty physicians furnishing services in a specialist care scarcity county, an additional amount equal to 5 percent of the amount paid for their professional services under the fee schedule from January 1, 2005 to December 31, 2007. We estimate that this new incentive payment for physicians' services will result in an increase in Medicare payments that are shown in Table 46.

b. Improvement to Medicare HPSA Incentive Payment Program

Section 413(b) of the MMA amended section 1833(m) of the Act to mandate that we automate payment of the 10 percent HPSA incentive payment to eligible physicians. Since the inception of the HPSA incentive payment program, physicians have been required to determine their eligibility and correctly code their Medicare claims using modifiers. We estimate that this change to the HPSA incentive payment program to provide for automation of payment will result in an increase in Medicare payments because many eligible physicians are not applying for bonuses due to the burden of verifying eligibility. The impact of this provision is shown in Table 46.

TABLE 46:
Medicare Cost Estimates for MMA Provisions
(in millions)

MMA Provision	FY05	FY06	FY07	FY08	FY09
Sec. 413(a) Physician Scarcity Areas	30	50	50	20	-
Sec. 413(b) Improvement to HPSA	20	30	30	30	30

5. Sections 303–304—Payment for Covered Outpatient Drugs and Biologicals and Section 305—Payment for Inhalation Drugs

Sections 303 and 304 of the MMA make changes to Medicare payment for covered outpatient drugs and biologicals and changes to the administration of those drugs. Section 305 makes changes to payment for inhalation drugs. We implemented provisions of sections 303 through 305 changing payments in 2004 for drugs and their administration in the January 7, 2004 **Federal Register** (69 FR 1084). In this final rule, we are making further changes to Medicare's payment for drugs and drug administration for 2005 required by sections 303 through 305 of the MMA. As indicated earlier in this final rule, we are revising the codes and payments for drug administration based on recommendations of the CPT Editorial Board and the Relative Value Update Committee. Consistent with section 1848(c)(2)(J) of the Act (as amended by section 303(a) of the MMA), the increase in payment resulting from this review are exempt from the budget neutrality requirements that apply to changes in RVUs. We are further increasing payments to physicians that treat patients with cancer who participate in a national demonstration project. In addition, we are also paying a supplying fee of $50 per month for the first month and $24 for each subsequent month for Medicare Part B oral drug prescriptions. We are also proposing to pay a furnishing fee of $0.14 per unit of clotting factor and a dispensing fee of $57 per month for inhalation drugs. Taking all of these provisions into account, we estimate Medicare savings for section 303–305 as follows:

TABLE 47:

Medicare Cost (Savings)
Estimates for MMA Provision 303-305
(in millions)

Provision	FY05	FY06	FY07	FY08	FY09
303-305	(730)	(1,300)	(1,650)	(1,820)	(1,990)

6. Section 952—Reassignment

The reassignment provisions discussed in section III.F is currently estimated to have no significant impact on Medicare expenditures.

7. Section 623—Payment for Renal Dialysis Services

a. Effects on the Medicare Program (Budgetary Effect)

Because the basic case mix adjusted composite payment rate and the revised payment for ESRD drugs must be budget neutral in accordance with section 623(d)(1) of the MMA, except for the statutorily required 1.6 percent increase set forth in section 623(a), we estimate that there would be no budgetary impact for the Medicare program beyond this increase. The impact of this provision (net of beneficiary liability) is shown in the following table:

TABLE 48:

Medicare Cost Estimates for MMA Provision 623
(in millions)

Provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Section 623	$40	$50	$50	$60	$60

b. Impact on ESRD Providers

To understand the impact of the changes affecting payments to ESRD facilities that result from enactment of the MMA on different categories of ESRD facilities, it is necessary to compare estimated payments under the current payment system (current payments) to estimated payments under the revisions to the composite rate payment system as set forth in this final rule (MMA payments). To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and MMA payments contain similar inputs. Therefore, we simulated MMA payments only for those ESRD facilities for which we are able to calculate both current payment and MMA payment.

Due to data limitations, we are unable estimate current and MMA payments for 461 facilities that bill for ESRD drugs. ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from HCRIS. We also used the June 2004 update of CY 2003 Standard Analytical File (SAF) claims as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. As we stated in the proposed rule, this final rule impact on providers uses updated OSCAR, cost report and claims data.

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Table 49:

Impact of MMA Section 623
Payments to Hospital Based and Independent ESRD Facilities
(Includes Drug and Composite Rate Payments)

[Percent change in total payments to ESRD facilities (both program and beneficiaries)]

	Number Of facilities	Number of Dialysis Treatments (in millions)	Effect of Changes In Drug Payments 1/	Effect of 1.6% Composite rate Update on Total Payments 2/	Effect of Case Mix 3/	Overall Effect 4/
All	3,907	31.0	0.0	1.0	0.0	1.0
Independent	3,390	27.5	-0.6	1.0	0.0	0.4
Hospital Based	517	3.5	5.2	1.1	0.3	6.6
Size						
Small <5000 treatment per year	1,274	3.9	0.2	1.0	0.5	1.5
Medium 5000-10000 treatments per yr	1,586	11.5	-0.3	1.0	0.1	0.7
Large > 10000 treatments per year	1,047	15.6	0.2	1.0	-0.2	1.0
Type of Ownership						
For-profit	2,782	22.6	-0.7	1.0	-0.2	0.1
Not-for-profit	785	5.8	3.0	1.1	0.4	4.3
Other	340	2.6	0.5	1.0	0.6	1.8
Urban	2,903	25.0	0.0	1.0	-0.1	0.9
Rural	1,004	6.0	-0.1	1.0	0.4	1.1
Region						
New England	128	1.1	0.8	1.0	-0.3	1.7
Middle Atlantic	498	4.3	0.5	1.0	-0.5	1.2

East North Central	570	4.6	0.3	1.0	1.0	1.9
West North Central	270	1.7	1.0	1.0	1.3	2.9
South Atlantic	920	7.2	-0.9	0.9	0.5	0.3
East South Central	317	2.3	-0.9	0.9	1.2	0.7
West South Central	530	4.3	-0.9	1.0	-0.3	-0.1
Mountain	204	1.3	2.4	1.0	-0.7	3.0
Pacific	442	3.8	0.8	1.0	-1.7	0.8
Puerto Rico	28	0.4	0.7	1.0	-4.1	-0.9

1/ This column shows the effect of the changes in drug payments to ESRD providers. These include changes in payment for separately billable drugs and the 8.7% drug add-on.

2/ This column shows the effect of the 1.6% update to the composite rate on total payments to ESRD providers. Note that ESRD providers receive an average of 39% of their total revenues from separately billable drugs which results in an average net increase of 1.0%.

3/ This column shows impact of case-mix adjustments only.

4/ This column shows the overall effect of payments to ESRD facilities with and without the application of MMA Section 623. The MMA provisions include the 1.6% increase, the 8.7% drug add-on, and the case-mix adjustments times treatments plus MMA payment for separately billable drugs. The current payment to ESRD facilities includes the current composite rate times treatments plus current drug payments for separately billable drugs.

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Table 49 shows the impact of MMA Section 623 on hospital based and independent facilities. We have included both composite rate payments as well as payments for separately billable drugs and biologicals because both are effected by section 623 of the MMA. The first column of Table 49 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments.

The fourth column shows the effect of the changes in drug payments to ESRD

providers. The overall effect of changes in drug payments is budget-neutral as required by MMA. The drug add-on adjustment is designed to result in the same aggregate amount of expenditures as would have been made without the statutory policy change.

Current payments for drugs represent 2005 Medicare reimbursement using 95 percent of AWP prices for the top ten drugs. Medicare spending for drugs other than EPO is estimated using 2004 AWP prices updated by a 3 percent inflation factor times actual drug utilization from 2003 claims. EPO is priced $10 per 1000 units (EPO units are estimated using payments because the units field on bills represents the number of EPO administrations rather than the number EPO units). Medicare spending under the MMA is 2003 average acquisition cost for the top ten drugs updated to 2005 figures (using the PPI for prescriptions drugs) times actual drug utilization from 2003 claims. These inflation factors were 4.81 percent and 3.72 percent for 2004 and 2005, respectively.

Payment for drugs under MMA also includes the 8.7 percent drug add-on to the composite rate. This amount is computed by multiplying the composite rate for each provider (with the 1.6 percent increase) times dialysis treatments from 2003 claims. Column 4 is computed by comparing spending under MMA provisions for drugs including the 8.7 percent drug add-on amount to spending under current payments for drugs. In order to make column 4 comparable with rest of Table 49, current composite rate payments to ESRD facilities were included in both current and MMA spending calculations.

Column 5 shows the effect of the 1.6 percent increase to the composite rate on total payments to ESRD providers. While all ESRD providers will get a 1.6 percent increase to their composite rate, this table shows the net effect of this increase on ESRD providers' total Medicare revenues (both drug and composite rate payments combined), and therefore does not show a 1.6 percent increase.

On average, ESRD providers receive an average of 39 percent of their total revenues from separately billable drugs and 61 percent of their total revenues from composite rate payment. Since the 1.6 percent increase is applied to the 61 percent portion of their total Medicare revenues, the 1.6 percent composite rate increase is also arithmetically equal to a 1.0 percent increase in ESRD providers' total Medicare revenues. Column 5 is computed by combining MMA payment for drugs (including the 8.7 percent drug add-on amount) with: (1) current composite rate times dialysis treatments from 2003 claims or (2) composite rate with 1.6 percent increase times dialysis treatments from 2003 claims. The difference between these two combinations is the net effect of the 1.6 percent increase on total payments to ESRD providers. In order to isolate the effect of the 1.6 percent increase, the computation in Column 5 assumes that drug payments to ESRD providers remain constant.

Column 6 shows the impact of the case-mix adjustments as described earlier in this preamble of this final rule. Because MMA requires this adjustment to be budget-neutral in the aggregate, there is no overall impact on ESRD providers as a whole. While the case-mix adjustment will have an impact within the various provider types, Column 6 shows that the effect between provider groupings is minimal. Column 6 is computed as the difference between payments to ESRD providers with the case-mix adjustments compared to payments to providers without the case-mix adjustments. As described earlier in this preamble, we developed a case-mix budget neutrality factor to meet the MMA requirement that payment be budget-neutral with respect to aggregate payments. Therefore, there is no change for ESRD providers in the aggregate. We note that when applying the case-mix adjustments, we did so at the facility level.

Column 7 shows the overall effect of all changes in drug and composite rate payments to ESRD providers. The overall effect of payments to ESRD facilities is measured as the difference between payment with and without application of MMA section 623 as described in this final rule and current payment. MMA payment is computed by multiplying the composite rate for each provider (with both 1.6 percent increase and the 8.7 percent add-on) times dialysis treatments from 2003 claims times the appropriate case-mix adjustment by provider. In addition, MMA payment includes payments for separately billable drugs under the revised pricing methodology as described in this preamble. Current payment is the current composite rate for each provider times dialysis treatments from 2003 claims plus current drug payments for separately billable drugs.

The overall impact to ESRD providers in aggregate is 1.0 percent. Among the three separately shown effects, the effect of changes in drug payments has the most variation among provider type and contributes most to the overall effect. Separately billable ESRD drugs are paid differently to hospital-based and independent ESRD providers. As discussed earlier in this preamble, we are using a single drug add-on to the composite rates for both hospital based and independent facilities. The 6.6 percent increase in payments to hospital-based providers is largely due to the single drug add-on to the composite rate.

8. Section 731—Coverage of Routine Costs for Category A Clinical Trials

The coverage of routine costs associated with certain Category A clinical trials as discussed in MMA section 731(b) will have no significant impact on Medicare expenditures.

9. Section 629—Part B Deductible

As explained earlier in the preamble, section 629 of the MMA provides for annual updates to the Medicare Part B deductible. The MMA stipulates that the Medicare Part B deductible will be $110 for calendar year 2005, and, for subsequent years, the deductible will be the previous year's deductible increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) of the Act, ending with that subsequent year (rounded to the nearest dollar). We note that while this MMA provision results in a savings to the Medicare program, it also increases beneficiary costs by an equal amount and was implemented in a **Federal Register** notice published on September 9, 2004 (69 FR 54675).

TABLE 50: ESTIMATED MEDICARE SAVINGS FOR MMA PROVISION 629

[in millions]

MMA provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 629	110	290	440	590	770

10. Section 512—Hospice Consultation Service

As explained in section III.K of this preamble, effective January 1, 2005, section 512 of the MMA provides for payment to be made to a hospice for specified services furnished by a physician who is either the medical director of, or an employee of, a hospice agency. We estimate that this MMA provision will increase Medicare expenditures by $10 million per year beginning in 2005.

11. Section 706 Coverage of Religious Nonmedical Health Care Institution (RNHCI) Services Furnished in the Home

We anticipate that the time limited RNHCI home benefit will either meet or fall short of the annual $700,000 per calendar year statutory spending limit and therefore will not have a significant financial impact on the Medicare program.

E. Other Issues

1. Outpatient Therapy Services Performed ''Incident To'' Physicians' Services

As discussed in section IV.A, we are amending the regulations to include the statutory requirement that only individuals meeting the existing qualification and training standards for therapists (with the exception of licensure) consistent with § 484.4 qualify to provide therapy services incident to physicians' services. We believe that while this will have little impact on Medicare expenditures, it will assist in ensuring the quality of services provided to beneficiaries.

2. Supervision Requirements for Therapy Assistants in Private Practice

As discussed earlier in section IV.A, we are revising the regulations at § 410.59 and § 410.60 to replace a requirement to provide personal supervision and instead require direct supervision of physical therapist assistants and occupational therapy assistants when therapy services are provided by physical therapists or occupational therapists in private practice. This policy change will provide beneficiaries access to medically necessary therapy services, under a physician-certified plan of care. We believe that this change could result in a 5 percent increase in therapy billing in therapy private practice settings with an estimated cost of $9 million for FY 2005. Projected costs for FY 2006 are $17 million while each subsequent year would only increase by $1 million each year, assuming the therapy caps are applied.

3. Low Osmolar Contrast Media

As discussed earlier in the preamble, we are revising the regulations at § 414.38 to eliminate the restrictive criteria for the payment of LOCM. This regulation will make payment for LOCM consistent across Medicare payment systems. Shown in the following table are estimates of program costs due to the removal of the restrictive criteria for administering LOCM, assuming increased utilization and removal of the 8 percent reduction. Without current ASP data, we could not include the additional impact of the change in payment for LOCM to ASP plus 6 percent, effective April 1, 2005. Contrast-enhanced procedures that most commonly use LOCM, the typical ranges of LOCM amounts used by modality, and the cost ranges for LOCM in the marketplace were considered in valuing the additional program costs.

TABLE 51:

Regulatory Provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
LOCM	20	30	30	30	30

4. Payments for Physicians and Practitioners Managing Patients on Dialysis

We believe that the proposals with respect to ESRD-related services furnished to patients in observation settings and payment for outpatient ESRD-related services for partial month scenarios discussed earlier in section xx provide clarification of current policy surrounding these issues. We do not believe these proposals will have a significant impact on Medicare expenditures.

5. Supervision of Clinical Psychological Testing

We are changing the supervision requirements regarding who can supervise diagnostic psychological testing services. As previously discussed, having ancillary staff supervised by clinical psychologists will enable these practitioners with a higher level of expertise to oversee psychological testing and potentially relieve burdens on physicians and healthcare facilities.

Additionally, in rural areas, we anticipate that permitting psychologists to supervise diagnostic psychological testing services will reduce delays in testing, diagnosis, and treatment that could result from the unavailability of physicians to supervise the tests. We believe that this revision to the supervision requirements will have little impact on Medicare expenditures.

6. Care Plan Oversight

As discussed earlier in the preamble, we are revising § 414.39 to clarify that NPPs can perform home health care plan oversight even though they cannot certify a patient for home health services and sign the plan of care. We do not expect that this change will have an impact on Medicare expenditures, since it is primarily a clarification in policy.

7. Assignment of Medicare Claims

The changes with respect to assignment of Medicare claims are currently estimated to have no significant impact on Medicare expenditures. However, as stated earlier in this preamble at section IV.G, we believe the changes will reduce the paperwork burden on beneficiaries and suppliers.

F. Alternatives Considered

This final rule contains a range of policies, including proposals related to specific MMA provisions. The preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised and presents rationale for our decisions and, when possible, alternatives that were considered.

G. Impact on Beneficiaries

There are a number of changes made in this rule that would have an effect on

beneficiaries. In general, we believe these changes will improve beneficiary access to services that are currently covered or will expand the Medicare benefit package to include new services. As explained in more detail below, the MMA or regulatory provisions may increase beneficiary liability in some cases. Any changes in aggregate beneficiary liability from a particular provision will be a function of the coinsurance (20 percent if applicable for the particular provision after the beneficiary has met the deductible) and the effect of the aggregate cost (savings) of the provision on the calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings).

The MMA provisions that expand Medicare benefits include: Section 611, adding an initial preventive physical exam for newly eligible Medicare beneficiaries; section 612 providing coverage of cardiovascular screening blood tests; and section 613, providing coverage for diabetes screening tests for Medicare beneficiaries at risk for diabetes. While the initial preventive physical examination for newly eligible Medicare beneficiaries is subject to deductible and coinsurance, we believe Medicare beneficiaries will continue to benefit from expanded coverage for this service. We believe many beneficiaries have supplemental insurance coverage or Medicaid that pays the Medicare deductible on their behalf and there will be no immediate additional out-of-pocket cost. Further, even if a beneficiary pays nearly all of the costs of this new benefit, the preventive office visit will substitute for another service a beneficiary may need to meet the annual deductible and the beneficiary will receive more covered benefits at little additional cost. There are no out-of-pocket costs to the beneficiary for the cardiovascular screening blood tests and diabetes screening tests.

Other proposals in this rule related to the MMA will also impact beneficiary liability, with the most significant related to indexing of the part B deductible (section 629 of the MMA) and the drug administration payment changes (sections 303 and 305 of the MMA). MMA provisions that improve administration of the 10 percent HPSA bonus and provide an additional 5 percent bonus payment to physicians in Medicare scarcity areas will have no impact on beneficiary liability because the bonus payments are applied to the amount Medicare pays the physician net of beneficiary liability. These provisions will also improve access for Medicare beneficiaries by increasing payments to physicians in areas that traditionally have had a low ratio of physicians to population.

We are summarizing the impact of all of the changes we are adopting in this rule in table 52. We note that Medicare savings estimates are relative to projected expenditures that would occur if the provisions of the MMA and this final regulation were not implemented. Thus, the savings figures are reductions in beneficiary liability relative to the amounts they otherwise would have paid. The figures do not necessarily mean that we are estimating that beneficiaries will have lower out-of-pocket costs in 2005 than 2004.

TABLE 52:
Estimated Medicare Beneficiary
Impact of MMA Provisions Being Implemented
In this Final Rule
(in millions)

Provision	FY 05	FY06	FY07	FY08	FY09
Sections 303-305	-$570	-$930	-$1,090	-$1,200	-$1,320
Section 611	20	20	20	20	20
Section 612	13	20	23	23	25
Section 613	5	10	13	15	20
Section 413(a)	8	13	13	5	-
Section 413(b)	5	8	8	8	8
Section 623	20	25	25	30	30
Section 629	110				
Section 512	5	5	5	5	5
LOCM	10	15	15	15	15
Physical Therapy	0	10	10	10	10

The implementation of MMA provisions related to drugs and drug administration will reduce Medicare beneficiary liability for Medicare covered services even after including the additional increases in payment for drug administration and establishing a supplying fee for immunosuppressive drugs, a furnishing fee for the clotting factor and a dispensing fee for immunosuppressive drugs. We do not believe that the drug and drug administration payment changes required by the MMA are intended to lessen beneficiary access to care. As indicated earlier, the changes we are making to Medicare payments for the administration of drugs are permanently increasing them by a weighted average of more than 117 percent between 2003 and 2005 and they are being increased by an additional 3 percent for 2005 only. While payments for drugs are being reduced between 2004 and 2005, the statute requires Medicare to pay for them at 6 percent more than their average sales price or the price they are purchased at in the market after taking into account rebates and discounts. Nevertheless, we acknowledge that there is a concern among physicians and others that the large changes in Medicare's payments may affect their ability or willingness to continue making drugs and related services available. CMS' Office of Research

Demonstrations and Information is analyzing Medicare utilization for drugs and drug administration beginning in 2002 and plans to continue to analyze the data for shifts or changes in utilization patterns as the information becomes available to us. To date, we have no evidence that beneficiaries are having any problems with access to drugs. While we do not believe the payment changes for drugs and drug administration will result in access problems, we plan to continue studying this issue. We also note that the MMA requires the Medicare Payment Advisory Commission (MedPAC) to study related issues. Specifically, section 303(a)(5) of the MMA requires MedPAC to study items and services furnished by oncologists and drug administration services furnished by other specialists.

We are also undertaking several changes using our administrative authority that will affect Medicare beneficiaries. Our proposal to remove restrictions that limit Medicare payment for use of low osmolar contrast material to specific indications would update Medicare's payment policy to be consistent with the standard practice of medicine and will improve the quality of care for beneficiaries.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 403

Grant programs-health, Health insurance, Hospitals, Intergovernmental relations, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medical devices, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 484

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 486

Grant programs-health, Health facilities, Medicare, Reporting and recordkeeping requirements, X-rays.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 403—SPECIAL PROGRAMS AND PROJECTS

Subpart G—Religious Nonmedical Health Care Institutions—Benefits, Conditions of Participation, and Payment

■ 1. The authority citation for part 403 continues to read as follows:

Authority: 42 U.S.C. 1359b–3 and secs 1102 and 1871 of the Social Security act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 403.746 is amended by adding a new paragraph (c) to read as follows:

§ 403.746 Condition of participation: Utilization review.

* * * * *

(c) *Standard: Utilization review committee role in RNHCI home services.* In addition to the requirements in paragraphs (a) and (b) of this section, the utilization review committee is responsible for:

(1) The admission, and at least every 30 days, the continued care review of each patient in the RHNCI home services program.

(2) Oversight and monitoring of the home services program, including the purchase and utilization of designated durable medical equipment items for beneficiaries in the program.

■ 3. In subpart G, § 403.764 through § 403.770 are added to read as follows:

§ 403.764 Basis and purpose of religious nonmedical health care institutions providing home service.

(a) *Basis.* This subpart implements sections 1821, 1861, 1861(e), 1861(m), 1861(y), 1861(ss) and 1861(aaa), 1869 and 1878 of the Act regarding Medicare payment for items and services provided in the home setting furnished to eligible beneficiaries by religious nonmedical health care institutions (RNHCIs).

(b) *Purpose.* The home benefit provides for limited durable medical equipment (DME) items and RNHCI services in the home setting that are fiscally limited to $700,000 per calendar year, with an expiration date of December 31, 2006, or the date on which the 2006 spending limit is reached.

§ 403.766 Requirements for coverage and payment of RNHCI home services.

(a) Medicare Part B pays for RNHCI home services if the RNHCI provider does the following:

(1) Submit a notice of intent to CMS to exercise the option of providing home service.

(2) Provide RNHCI services to eligible beneficiaries,

(3) Arrange with suppliers to furnish appropriate DME items as required to meet documented eligible beneficiary needs.

(4) Arrange for RNHCI nurse home visits to eligible beneficiaries.

(5) Have a utilization committee that assumes the additional responsibility for the oversight and monitoring of the items and RNHCI nursing services provided under the home benefit.

(6) Meet all applicable requirements set forth in subpart G of this part.

(b) To be an eligible beneficiary to RNHCI home services the beneficiary must:

(1) Have an effective election in place.

(2) Be confined to the home, as specified in § 409.42(a) of this chapter.

(3) Have a condition that makes him or her eligible to receive services covered under Medicare home health.

(4) Receive home services and DME items from a RNHCI.

(5) Be responsible for deductible and coinsurance for DME, as specified in § 409.50 of this chapter.

§ 403.768 Excluded services.

In addition to items and services excluded in § 409.49 of this chapter, items and services are also excluded if they are provided by:

(a) A HHA that is not a RNHCI.

(b) A supplier who is not providing RNHCI designated items under arrangement with a RNHCI.

(c) A nurse who is not providing RNHCI home nursing services under arrangement with a RNHCI.

§ 403.770 Payments for home services.

(a) The RNHCI nursing visits are paid at the modified low utilization payment

adjusted (LUPA) rate used under the home health prospective payment system at § 484.230 of this chapter.

(b) Appropriate DME items are paid as priced by Medicare, minus the deductible and coinsurance liability of the beneficiary.

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

■ 4. The authority citation for part 405 continues to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr, and 1395ww(k)), and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

■ 5. Section 405.207 is amended by revising paragraph (b) to read as follows:

§ 405.207 Services related to a noncovered device.

* * * * *

(b) *When payment is made.* Medicare payment may be made for—

(1) Covered services to treat a condition or complication that arises due to the use of a noncovered device or a noncovered device-related service; or

(2) Routine care services related to experimental/investigational (Category A) devices as defined in § 405.201(b); and furnished in conjunction with an FDA-approved clinical trial. The trial must meet criteria established through the national coverage determination process; and if the trial is initiated before January 1, 2010, the device must be determined as intended for use in the diagnosis, monitoring or treatment of an immediately life-threatening disease or condition.

(3) Routine care services related to a non-experimental/investigational (Category B) device defined in § 405.201(b) that is furnished in conjunction with an FDA-approved clinical trial.

■ 6. Section 405.517 is amended by adding a new paragraph (a)(3) to read as follows:

§ 405.517 Payment for drugs and biologicals that are not paid on a cost or prospective payment basis.

(a) *Applicability.* * * *

(3) *Payment for drugs and biologicals on or after January 1, 2005.* Effective January 1, 2005, payment for drugs and biologicals that are not paid on a cost or prospective payment basis are paid in accordance with part 414, subpart K of this chapter.

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 7. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 8. Section 410.1 is amended by adding a new paragraph (a)(6) to read as follows:

§ 410.1 Basis and scope.

(a) * * *

(6) Section 1842(o)—Payment for drugs and biologicals not paid on a cost or prospective payment basis.

* * * * *

■ 9. Section 410.10 is amended by adding new paragraph (y) to read as follows:

§ 410.10 Medical and other health services: Included services.

* * * * *

(y) Intravenous immune globulin administered in the home for the treatment of primary immune deficiency diseases.

■ 10. Section 410.16 is added to read as follows:

§ 410.16 Initial preventive physical examination: Conditions for and limitations on coverage.

(a) *Definitions.* As used in this section, the following definitions apply:

Eligible beneficiary means an individual who receives his or her initial preventive physical examination within 6 months after the effective date of his or her first Medicare Part B coverage period, but only if that first Part B coverage period begins on or after January 1, 2005.

Initial preventive physical examination means all of the following services furnished to an eligible beneficiary by a physician or other qualified nonphysician practitioner with the goal of health promotion and disease detection:

(1) Review of the beneficiary's medical and social history with attention to modifiable risk factors for disease, as those terms are defined in this section.

(2) Review of the beneficiary's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified nonphysician practitioner may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.

(3) Review of the beneficiary's functional ability, and level of safety as those terms are defined in this section, as described in paragraph (4) of this definition, based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified nonphysician practitioner may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

(4) An examination to include measurement of the beneficiary's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's medical and social history, and current clinical standards.

(5) Performance and interpretation of an electrocardiogram.

(6) Education, counseling, and referral, as deemed appropriate by the physician or qualified nonphysician practitioner, based on the results of the review and evaluation services described in this section.

(7) Education, counseling, and referral, including a brief written plan such as a checklist provided to the beneficiary for obtaining the appropriate screening and other preventive services that are covered as separate Medicare Part B benefits as described in section 1861(s)(10), section 1861(jj), section 1861(nn), section 1861(oo), section 1861(pp), section 1861(qq)(1), section 1861(rr), section 1861(uu), section 1861(vv), section 1861(xx)(1), and section 1861(yy) of the Act.

Medical history is defined to include, at a minimum, the following:

(1) Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments.

(2) Current medications and supplements, including calcium and vitamins.

(3) Family history, including a review of medical events in the beneficiary's family, including diseases that may be hereditary or place the individual at risk.

A *physician* for purposes of this section means a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

A qualified nonphysician practitioner for purposes of this section means a physician assistant, nurse practitioner, or clinical nurse specialist (as authorized under section 1861(s)(2)((K)(i) and section

1861(s)(2)((K)(ii) of the Act and defined in section 1861(aa)(5) of the Act, or in § 410.74, § 410.75, and § 410.76).

Review of the beneficiary's functional ability and level of safety must include, at a minimum, a review of the following areas:

(1) Hearing impairment.
(2) Activities of daily living.
(3) Falls risk.
(4) Home safety

Social history is defined to include, at a minimum, the following:

(1) History of alcohol, tobacco, and illicit drug use.
(2) Diet.
(3) Physical activities.

(b) *Condition for coverage of an initial preventive physical examination.* Medicare Part B pays for an initial preventive physical examination provided to an eligible beneficiary, as described in this section, if it is furnished by a physician or other qualified nonphysician practitioner, as defined in this section.

(c) *Limitations on coverage of initial preventive physical examinations.* Payment may not be made for an initial preventive physical preventive examination that is performed for an individual who is not an eligible beneficiary as described in this section.

■ 11. A new § 410.17 is added to read as follows:

§ 410.17 Cardiovascular disease screening tests.

(a) *Definition.* For purposes of this subpart, the following definition apply:

Cardiovascular screening blood test means:

(1) A lipid panel consisting of a total cholesterol, HDL cholesterol, and triglyceride. The test is performed after a 12-hour fasting period.

(2) Other blood tests, previously recommended by the U.S. Preventive Services Task Force (USPSTF), as determined by the Secretary through a national coverage determination process.

(3) Other non-invasive tests, for indications that have a blood test recommended by the USPSTF, as determined by the Secretary through a national coverage determination process.

(b) *General conditions of coverage.* Medicare Part B covers cardiovascular disease screening tests when ordered by the physician who is treating the beneficiary (*see* § 410.32(a)) for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms of cardiovascular disease.

(c) *Limitation on coverage of cardiovascular screening tests.* Payment may be made for cardiovascular screening tests performed for an asymptomatic individual only if the individual has not had the screening tests paid for by Medicare during the preceding 59 months following the month in which the last cardiovascular screening tests were performed.

■ 12. A new § 410.18 is added to read as follows:

§ 410.18 Diabetes screening tests.

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

Diabetes means diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a 2-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Pre-diabetes means a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting glucose level of 100—125 mg/dL, or a 2-hour post-glucose challenge of 140—199 mg/dL. The term pre-diabetes includes the following conditions:

(1) Impaired fasting glucose.
(2) Impaired glucose tolerance.

(b) *General conditions of coverage.* Medicare Part B covers diabetes screening tests after a referral from a physician or qualified nonphysician practitioner to an individual at risk for diabetes for the purpose of early detection of diabetes.

(c) *Types of tests covered.* The following tests are covered if all other conditions of this subpart are met:

(1) Fasting blood glucose test.

(2) Post-glucose challenges including, but not limited to, an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults, a 2-hour post glucose challenge test alone.

(3) Other tests as determined by the Secretary through a national coverage determination.

(d) *Amount of testing covered.* Medicare covers the following for individuals:

(1) Diagnosed with pre-diabetes, two screening tests per calendar year.

(2) Previously tested who were not diagnosed with pre-diabetes, or who were never tested before, one screening test per year.

(e) *Eligible risk factors.* Individuals with the following risk factors are eligible to receive the benefit:

(1) Hypertension.
(2) Dyslipidemia.
(3) Obesity, defined as a body mass index greater than or equal to 30 kg/m^2.
(4) Prior identification of impaired fasting glucose or glucose intolerance.
(5) Any two of the following characteristics:
(i) Overweight, defined as body mass index greater than 25, but less than 30 kg/m^2.
(ii) A family history of diabetes.
(iii) 65 years of age or older.
(iv) A history of gestational diabetes mellitus or delivery of a baby weighing more than 9 pounds.

■ 13. Section 410.26 is amended by revising paragraph (c) to read as follows:

§ 410.26 Services and supplies incident to a physician's professional services: Conditions.

* * * * *

(c) *Limitations.* (1) Drugs and biologicals are also subject to the limitations specified in § 410.29.

(2) Physical therapy, occupational therapy and speech-language pathology services provided incident to a physician's professional services are subject to the provisions established in § 410.59(a)(3)(iii), § 410.60(a)(3)(iii), and § 410.62(a)(3)(ii).

■ 14. Section 410.32 is amended by revising paragraph (b)(2)(iii) to read as follows:

§ 410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

* * * * *

(b) * * *
(2) * * *

(iii) Diagnostic psychological testing services when—

(A) Personally furnished by a clinical psychologist or an independently practicing psychologist as defined in program instructions; or

(B) Furnished under the general supervision of a physician or a clinical psychologist.

* * * * *

■ 15. Section 410.59 is amended by—
■ A. Revising paragraph (a) introductory text and paragraph (a)(3)(ii).
■ B. Adding new paragraph (a)(3)(iii).
■ C. Revising paragraph (b) heading.
■ C. Revising paragraph (c)(2).
■ D. Adding new paragraph (e)(1)(iii).

The additions and revisions read as follows:

§ 410.59 Outpatient occupational therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient occupational therapy services only if they are furnished by an individual meeting the qualifications in § 484.4 of

this chapter for an occupational therapist or by an appropriately supervised occupational therapy assistant but only under the following conditions:

* * * * *

(3) * * *

(ii) By, or under the direct supervision of, an occupational therapist in private practice as described in paragraph (c) of this section; or

(iii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform occupational therapy services within the scope of State law. When an occupational therapy service is provided incident to the service of a physician, physician assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to occupational therapy and occupational therapists, except that a license to practice occupational therapy in the State is not required.

(b) *Conditions for coverage of outpatient therapy services furnished to certain inpatients of a hospital or a CAH or SNF.* * * *

(c) * * *

(2) *Supervision of occupational therapy services.* Occupational therapy services are performed by, or under the direct supervision of, an occupational therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, directly supervised by the therapist, and included in the fee for the therapist's services.

* * * * *

(e) * * *

(1) * * *

(iii) The limitation is not applied for services furnished from December 8, 2003 through December 31, 2005.

* * * * *

■ 16. Section 410.60 is amended by—

■ A. Revising paragraph (a) introductory text.

■ B. Revising paragraph (a)(3)(ii).

■ C. Adding new paragraph (a)(3)(iii).

■ D. Revising paragraph (b) heading.

■ E. Revising paragraph (c)(2).

■ F. Adding new paragraph (e)(1)(iii).

The additions and revisions read as follows:

§ 410.60 Outpatient physical therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient physical therapy services only if they are furnished by an individual meeting the qualifications in § 484.4 of this chapter for a physical therapist or by an appropriately supervised physical therapist assistant but only under the following conditions:

* * * * *

(3) * * *

(ii) By, or under the direct supervision of a physical therapist in private practice as described in paragraph (c) of this section; or

(iii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform physical therapy services under State law. When a physical therapy service is provided incident to the service of a physician, physician's assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to physical therapy and physical therapists, except that a license to practice physical therapy in the State is not required.

(b) *Condition for coverage of outpatient physical therapy services furnished to certain inpatients of a hospital or a CAH or SNF.* * * *

(c) * * *

(2) *Supervision of physical therapy services.* Physical therapy services are performed by, or under the direct supervision of, a physical therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, directly supervised by the therapist, and included in the fee for the therapist's services.

* * * * *

(e) * * *

(1) * * *

(iii) The limitation is not applied for services furnished from December 8, 2003 through December 31, 2005.

* * * * *

■ 17. Section 410.62 is amended by—

■ A. Revising paragraph (a) introductory text and (a)(2)(i), (a)(2)(iii) and (a)(3).

■ B. Revising paragraphs (b) and (c).

The revisions read as follows:

§ 410.62 Outpatient speech-language pathology services: Conditions and exclusions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(ii) of this section, Medicare Part B pays for outpatient speech-language pathology services only if they are furnished by an individual who meets the qualifications for a speech-language pathologist in § 484.4 of this chapter and only under the following conditions:

* * * * *

(2) * * *

(i) Is established by a physician or, effective January 1, 1982, by either a physician or the speech-language pathologist who provides the services to the particular individual;

(ii) * * *

(iii) Meets the requirements of § 410.61.

(3) They are furnished—

(i) By a provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform speech-language pathology services under State law. When a speech-language pathology service is provided incident to the services of a physician, physician assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to speech-language pathology and speech-language pathologists, except that a license to practice speech-language pathology services in the State is not required.

(b) *Condition for coverage of outpatient speech-language pathology services to certain inpatients of a hospital, CAH, or SNF.* Medicare Part B pays for outpatient speech-language pathology services furnished to an inpatient of a hospital, CAH, or SNF who requires the services but has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) Excluded services. No service is included as an outpatient speech-language pathology service if it is not included as an inpatient hospital service if furnished to a hospital or CAH inpatient.

* * * * *

■ 18. Section 410.63 is amended by—

■ A. Revising paragraph (b) heading.

■ B. Adding a new paragraph (c).

The revision and addition reads as follows:

§ 410.63 Hepatitis B vaccine and blood clotting factors: Conditions.

* * * * *

(b) *Blood clotting factors: Conditions.* * * *

(c) *Blood clotting factors: Furnishing Fee.*

(1) Effective January 1, 2005, a furnishing fee of $0.14 per unit of clotting factor is paid to entities that furnish blood clotting factors unless the costs associated with furnishing the clotting factor are paid through another payment system, for example, hospitals that furnish clotting factor to patients during a Part A covered inpatient hospital stay.

(2) The furnishing fee for blood clotting factors furnished in 2006 or a subsequent year is be equal to the furnishing fee paid the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

■ 19. Section 410.78 is amended by—
■ A. Revising paragraph (a)(4).
■ B. Revising paragraph (b) introductory text.

The revisions read as follows:

§ 410.78 Telehealth services.

* * *

(4) *Originating site* means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous store and forward telecommunications technologies, the only originating sites are Federal telemedicine demonstration programs conducted in Alaska or Hawaii.

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management and end stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site) furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

■ 20. Section 410.160 is amended by revising paragraph (f) to read as follows:

§ 410.160 Part B annual deductible.

* * * * *

(f) *Amount of the Part B annual deductible.* (1) Beginning with expenses for services furnished during calendar year 2006, and for all succeeding years, the annual deductible is the previous year's deductible plus the annual percentage increase in the monthly actuarial rate for Medicare enrollees age 65 and over, rounded to the nearest dollar.

(2) For 2005, the deductible is $110.

(3) From 1991 through 2004, the deductible was $100.

(4) From 1982 through 1990, the deductible was $75.

(5) From 1973 through 1981, the deductible was $60.

(6) From 1966 through 1972, the deductible was $50.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 21. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 22. Section 411.15 is amended by—
■ A. Revising paragraph (a)(1).
■ B. Adding paragraph (k)(11).

The revision and addition read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(a) * * *

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, or initial preventive physical examinations that meet the criteria specified in paragraphs (k)(6) through (k)(11) of this section.

* * * * *

(k) * * *

(11) In the case of initial preventive physical examinations, with the goal of health promotion and disease prevention, subject to the conditions and limitations specified in § 410.16 of this chapter.

* * * * *

■ 23. Section 411.404 is amended by revising paragraph (b) to read as follows:

§ 411.404 Criteria for determining that a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary.

* * * * *

(b) *Written notice.* (1) Written notice is given to the beneficiary, or to someone acting on his or her behalf, that the services were not covered because they did not meet Medicare coverage guidelines.

(2) A notice concerning similar or reasonably comparable services furnished on a previous occasion also meets this criterion.

(3) After a beneficiary is notified that there is no Medicare payment for a service that is not covered by Medicare, he or she is presumed to know that there is no Medicare payment for any form of subsequent treatment for the non-covered condition.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES.

■ 24. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

§ 414.38 [Removed]

■ 25. Section 414.38 is removed.
■ 26. Section 414.39 is amended by—
■ A. Revising paragraph (a).
■ B. Adding paragraph (c).

The revision and addition read as follows:

§ 414.39 Special rules for payment of care plan oversight.

(a) *General.* Except as specified in paragraphs (b) and (c) of this section, payment for care plan oversight is included in the payment for visits and other services under the physician fee schedule. For purposes of this section a nonphysician practitioner (NPP) is a nurse practitioner, clinical nurse specialist or physician assistant.

* * * * *

(c) *Special rules for payment of care plan oversight provided by nonphysician practitioners for beneficiaries who receive HHA services covered by Medicare.*

(1) An NPP can furnish physician care plan oversight (but may not certify a patient as needing home health services) if the physician who signs the plan of care provides regular ongoing care under the same plan of care as does the NPP billing for care plan oversight and either:

(i) The physician and NPP are part of the same group practice; or

(ii) If the NPP is a nurse practitioner or clinical nurse specialist, the physician signing the plan of care also has a collaborative agreement with the NPP; or

(iii) If the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of physician assistant services for the practice.

(2) Payment may be made for care plan oversight services furnished by an NPP when:

(i) The NPP providing the care plan oversight has seen and examined the patient;

(ii) The NPP providing care plan oversight is not functioning as a

consultant whose participation is limited to a single medical condition rather than multi-disciplinary coordination of care; and

(iii) The NPP providing care plan oversight integrates his or her care with that of the physician who signed the plan of care.

■ 27. Section 414.65 is amended by revising paragraph (a)(1) to read as follows:

§ 414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, pharmacologic management and end stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site) furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

* * * * *

■ 28. Section 414.66 is added to subpart B to read as follows:

§ 414.66 Incentive payments for physician scarcity areas.

(a) *Definition.* As used in this section, the following definitions apply.

Physician scarcity area is defined as an area with a shortage of primary care physicians or specialty physicians to the Medicare population in that area.

Primary care physician is defined as a general practitioner, family practice practitioner, general internist, obstetrician or gynecologist.

(b) Physicians' services furnished to a beneficiary in a Physician Scarcity Area (PSA) for primary or specialist care are eligible for a 5 percent incentive payment.

(c) Primary care physicians furnishing services in primary care PSAs are entitled to an additional 5 percent incentive payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

(d) Physicians, as defined in section 1861(r)(1) of the Act, furnishing services in specialist care PSAs are entitled to an additional 5 percent payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

■ 29. Section 414.67 is added to subpart B to read as follows:

§ 414.67 Incentive payments for Health Professional Shortage Areas.

(a) Physicians' services furnished to a beneficiary in a geographic-based Health Professional Shortage Area (HPSA) are eligible for a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(b) Physicians furnishing services in a geographic-based primary medical care HPSA are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(c) Psychiatrists furnishing services in a mental health HPSA are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule. (The only physicians eligible to receive the 10 percent incentive payment in mental health HPSAs that do not overlap with primary care HPSAs are psychiatrists.)

■ 30. Part 414 is amended by adding a new subpart K to read as follows:

Subpart K—Payment for Drugs and Biologicals in 2005

Sec.

Subpart K—Payment for Drugs and Biologicals in 2005

§ 414.900 Basis.

(a) This subpart implements section 1842(o) of the Act by specifying the methodology for determining the payment allowance limit for drugs and biologicals covered under Medicare Part B that are not paid on a cost or prospective payment system basis.

(b) Examples of drugs that are subject to the requirements specified in this subpart are:

(1) Drugs furnished incident to a physician's service; durable medical equipment (DME) drugs.

(2) Separately billable drugs at independent dialysis facilities not under the ESRD composite rate.

(3) Statutorily covered drugs, for example—

(i) Influenza.

(ii) Pneumococcal and hepatitis vaccines.

(iii) Antigens.

(iv) Hemophilia blood clotting factor.

(v) Immunosuppressive drugs.

(vi) Certain oral anti-cancer drugs.

§ 414.902 Definitions.

As used in this subpart, unless the context indicates otherwise—

Drug means both drugs and biologicals.

Manufacturer's average sales price means the price calculated and reported by a manufacturer under part 414, subpart J of this chapter.

Multiple source drug means a drug described by section 1847A(c)(6)(C) of the Act.

Single source drug means a drug described by section 1847A(c)(6)(D) of the Act.

Unit is defined as in part 414, subpart J of this chapter.

Wholesale acquisition cost (WAC) means the price described by section 1847A(c)(6)(B) of the Act.

§ 414.904 Basis of payment.

(a) *Method of payment.* Payment for a drug for calendar year 2005 is based on the lesser of—

(1) The actual charge on the claim for program benefits; or

(2) 106 percent of the average sales price, subject to the applicable limitations specified in paragraph (d) of this section or subject to the exceptions described in paragraph (e) of this section.

(b) *Multiple source drugs.* (1) *Average sales prices.* The average sales price for all drug products included within the same multiple source drug billing and payment code is the volume-weighted average of the manufacturers' average sales prices for those drug products.

(2) *Calculation of the average sales price.* The average sales price is determined by—

(i) Computing the sum of the products (for each National Drug Code assigned to the drug products) of the manufacturer's average sales price and the total number of units sold; and

(ii) Dividing that sum by the sum of the total number of units sold for all NDCs assigned to the drug products.

(c) *Single source drugs.* (1) *Average sales price.* The average sales price is the volume-weighted average of the manufacturers' average sales prices for all National Drug Codes assigned to the drug or biological product.

(2) *Calculation of the average sales price.* The average sales price is determined by computing—

(i) The sum of the products (for each National Drug Code assigned to the drug product) of the manufacturer's average sales price and the total number of units sold; and

(ii) Dividing that sum by the sum of the total number of units sold for all NDCs assigned to the drug product.

(d) *Limitations on the average sales price.* (1) *Wholesale acquisition cost for a single source drug.* The payment limit for a single source drug product is the lesser of 106 percent of the average sales price for the product or 106 percent of

the wholesale acquisition cost for the product.

(2) *Payment limit for a drug furnished to an end-stage renal disease patient.* (i) Effective for drugs and biologicals furnished in 2005, the payment for such drugs and biologicals, including erythropoietin, furnished to an end-stage renal disease patient that is separately billed by an end-stage renal disease facility and not paid on a cost basis is acquisition cost as determined by the Inspector General report as required by section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 inflated by the percentage increase in the Producer Price Index.

(ii) Except as provided in paragraph (a) of this section, the payment for drugs and biologicals, furnished to an end-stage renal disease patient that is separately billed by an end-stage renal disease facility, is based on 106 percent of the average sales price.

(3) *Widely available market price and average manufacturer price.* If the Inspector General finds that the average sales price exceeds the widely available market price or the average manufacturer price by 5 percent or more in calendar year 2005, the payment limit in the quarter following the transmittal of this information to the Secretary is the lesser of the widely available market price or 103 percent of the average manufacturer price.

(e) *Exceptions to the average sales price.* (1) *Vaccines.* The payment limits for hepatitis B vaccine furnished to individuals at high or intermediate risk of contracting hepatitis B (as determined by the Secretary), pneumococcal vaccine, and influenza vaccine and are calculated using 95 percent of the average wholesale price.

(2) *Infusion drugs furnished through a covered item of durable medical equipment.* The payment limit for an infusion drug furnished through a covered item of durable medical equipment is calculated using 95 percent of the average wholesale price in effect on October 1, 2003 and is not updated in 2005.

(3) *Blood and blood products.* In the case of blood and blood products (other than blood clotting factors), the payment limits are determined in the same manner as the payment limits were determined on October 1, 2003.

(4) *Payment limit in a case where the average sales price during the first quarter of sales is unavailable.* In the case of a drug during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales of the drug are not sufficiently available from the manufacturer to compute an average sales price for the drug, the payment limit is based on the wholesale acquisition cost or the applicable Medicare Part B drug payment methodology in effect on November 1, 2003.

(f) Except as otherwise specified (see paragraph (e)(2) of this section) for infusion drugs, the payment limits are updated quarterly.

(g) The payment limit is computed without regard to any special packaging, labeling, or identifiers on the dosage form or product or package.

(h) The payment amount is subject to applicable deductible and coinsurance.

■ 31. Part 414 is amended by adding a new subpart L to read as follows:

Subpart L—Supplying and Dispensing Fees

Sec.
414.1000 Purpose.
414.1001 Basis of Payment.

§ 414.1000 Purpose.

This subpart implements section 1842(o)(2) and section 1842(o)(6) of the Act, as added by section 303(e)(2) of the MMA, by specifying a supplying fee for drugs and biologicals covered under Part B of Title XVIII of the Act that are described in sections 1861(s)(2)(J), 1861(s)(2)(Q), and 1861(s)(2)(T) of the Act.

§ 414.1001 Basis of payment.

(a) A supplying fee of $24 shall be paid to a pharmacy for each supplied prescription of drugs and biologicals described in sections 1861(s)(2)(J), 1861(s)(2)(Q), and 1861(s)(2)(T) of the Act.

(b) A supplying fee of $50 is paid to a pharmacy for the initial supplied prescription of drugs and biologicals described in sections 1861(s)(2)(J) of the Act provided to a patient during the first month following a transplant.

(c) During 2005, a dispensing fee of $57 is paid to a supplier for each dispensed 30-day supply of inhalation drugs furnished through durable medical equipment covered under section 1861(n) of the Act, regardless of the number of partial shipments of that 30-day supply.

(d) During 2005, a dispensing fee of $80 is paid to a supplier for each dispensed 90-day supply of inhalation drugs furnished through durable medical equipment covered under section 1861(n) of the Act, regardless of the number of partial shipments of that 90-day supply.

PART 418—HOSPICE CARE

■ 32. The authority citation for part 418 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 33. Section 418.205 is added to subpart F to read as follows:

§ 418.205 Special requirements for hospice pre-election evaluation and counseling services.

(a) *Definition.* As used in this section the following definition applies.

Terminal illness has the same meaning as defined in § 418.3.

(b) *General.* Effective January 1, 2005, payment for hospice pre-election evaluation and counseling services as specified in §418.304(d) may be made to a hospice on behalf of a Medicare beneficiary if the requirements of this section are met.

(1) *The beneficiary.* The beneficiary:

(i) Has been diagnosed as having a terminal illness as defined in § 418.3.

(ii) Has not made a hospice election.

(iii) Has not previously received hospice pre-election evaluation and consultation services specified under this section.

(2) *Services provided.* The hospice pre-election services include an evaluation of an individual's need for pain and symptom management and counseling regarding hospice and other care options. In addition, the services may include advising the individual regarding advanced care planning.

(3) *Provision of pre-election hospice services.*

(i) The services must be furnished by a physician.

(ii) The physician furnishing these services must be an employee or medical director of the hospice billing for this service.

(iii) The services cannot be furnished by hospice personnel other than employed physicians, such as but not limited to nurse practitioners, nurses, or social workers, physicians under contractual arrangements with the hospice or by the beneficiary's physician, if that physician is not an employee of the hospice.

(iv) If the beneficiary's attending physician is also the medical director or a physician employee of the hospice, the attending physician may not provide nor may the hospice bill for this service because that physician already possesses the expertise necessary to furnish end-of-life evaluation and management, and counseling services.

(4) *Documentation.* (i) If the individual's physician initiates the request for services of the hospice medical director or physician, appropriate documentation is required.

(ii) The request or referral must be in writing, and the hospice medical

director or physician employee is expected to provide a written note on the patient's medical record.

(iii) The hospice agency employing the physician providing these services is required to maintain a written record of the services furnished.

(iv) If the services are initiated by the beneficiary, the hospice agency is required to maintain a record of the services and documentation that communication between the hospice medical director or physician and the beneficiary's physician occurs, with the beneficiary's permission, to the extent necessary to ensure continuity of care.

■ 34. Section 418.304 is amended by adding paragraph (d) to read as follows.

§ 418.304 Payment for physician services.

* * * * *

(d) *Payment for hospice pre-election evaluation and counseling services.* The intermediary makes payment to the hospice for the services established in § 418.205. Payment for this service is set at an amount established under the physician fee schedule, for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decision-making of low complexity other than the portion of the amount attributable to the practice expense component. Payment for this pre-election service does not count towards the hospice cap amount.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 35. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 36. Section 424.55 is amended by adding new paragraph (c) to read as follows:

§ 424.55 Payment to the supplier.

* * * * *

(c) *Exception.* In situations when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, the beneficiary (or the person authorized to request payment on the beneficiary's behalf) is not required to assign the claim to the supplier in order for an assignment to be effective.

■ 37. Section 424.71 is amended as follows:

■ A. The definition of ''Health care delivery system or system'' is removed.

■ B. The definition of the term ''Entity'' is added in alphabetical order.

The addition reads as follows:

§ 424.71 Definitions.

* * * * *

Entity means a person, group, or facility that is enrolled in the Medicare program.

* * * * *

■ 38. Section 424.80 is amended by—

■ A. Revising paragraph (a).

■ B. Revising paragraph (b)(2).

■ C. Removing paragraph (b)(3).

■ D. Redesignating paragraphs (b)(4) through (6) as paragraphs (b)(3) through (5), respectively.

■ E. Revising paragraph (c).

■ F. Adding a new paragraph (d).

The revisions and addition read as follows:

§ 424.80 Prohibition of reassignment of claims by suppliers.

(a) *Basic prohibition.* Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a supplier under an assignment to any other person under reassignment, power of attorney, or any other direct arrangement. Nothing in this section alters a party's obligations under the anti-kickback statute (section 1128B(b) of the Act), the physician self-referral prohibition (section 1877 of the Act), the rules regarding physician billing for purchased diagnostic tests (§ 414.50 of this chapter), the rules regarding payment for services and supplies incident to a physician's professional services (§ 410.26 of this chapter), or other laws, rules, and regulations.

(b) * * *

(1) * * *

(2) *Payment to an entity under a contractual arrangement.* Medicare may pay an entity enrolled in the Medicare program if there is a contractual arrangement between the entity and the supplier under which the entity bills for the supplier's services, subject to the provisions of paragraph (d) of this section.

* * * * *

(c) *Rules applicable to an employer or entity.* An employer or entity that may receive payment under paragraph (b)(1) or (b)(2) of this section is considered the supplier of those services for purposes of subparts C, D, and E of this part, subject to the provisions of paragraph (d) of this section.

(d) *Reassignment to an entity under a contractual arrangement: Conditions and limitations.* (1) *Liability of the parties.* An entity enrolled in the Medicare program that receives payment under a contractual arrangement under paragraph (b)(2) of this section and the supplier that otherwise receives payment are jointly and severally responsible for any Medicare overpayment to that entity.

(2) *Access to records.* The supplier furnishing the service has unrestricted access to claims submitted by an entity for services provided by that supplier.

PART 484—HOME HEALTH SERVICES

■ 39. The authority citation for part 484 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 484.4 [Amended]

■ 40. In § 484.4 in the definition of physical therapy assistant the term ''physical therapy assistant'' is removed and the term ''physical therapist assistant'' is added in its place wherever it appears.

PART 486—CONDITIONS FOR COVERAGE OF SPECIALIZED SERVICES FURNISHED BY SUPPLIERS

■ 41. The authority citation for part 486 continues to read as follows:

Authority: Sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart D—[Removed and Reserved]

■ 42. Part 486 subpart D, consisting of § 486.150 through § 486.163, is removed and reserved.

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 1, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 1, 2004.

Tommy G. Thompson,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A—Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2005. Addendum B contains the RVUs for work, non-facility practice expense, facility practice expense, and malpractice expense, and other information for all services included in the physician fee schedule.

In previous years, we have listed many services in Addendum B that are not paid under the physician fee schedule. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes and most alphanumeric

codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) in Addendum B.

Addendum B—2005 Relative Value Units and Related Information Used in Determining Medicare Payments for 2005

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics), and codes for anesthesiology.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier -26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code: one for the global values (both professional and technical); one for modifier -26 (PC); and one for modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier -53 is shown for a discontinued procedure. There will be RVUs for the code (CPT code 45378) with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is included 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. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national decision regarding the coverage of the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)

C = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.

E = Excluded from physician fee schedule by regulation. These codes are for items or services that we chose to exclude from the physician fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the physician fee schedule for these codes. Payment for them, if they are covered, continues under reasonable charge or other payment procedures.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Code not subject to a 90-day grace period.)

N = Noncovered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

P = Bundled or excluded code. There are no RVUs for these services. No separate payment should be made for them under the physician fee schedule.

—If the item or service is covered as incident to a physician's service and is furnished on the same day as a physician's service, payment for it is bundled into the payment for the physician's service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician's service).

—If the item or service is covered as other than incident to a physician's service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = Injections. There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of ''physicians' services'' for physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2005. Codes that are not used for Medicare payment are identified with a ''+.''

6. *Facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for facility settings.

7. *Non-facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for non-facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2005.

9. *Facility total.* This is the sum of the work, fully implemented facility practice expense, and malpractice expense RVUs.

10. *Non-facility total.* This is the sum of the work, fully implemented non-facility practice expense, and malpractice expense RVUs.

11. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and practice expense are associated with intra-service time and in some instances the post-service time.)

BILLING CODE 4120–01–P

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
0003T		C	Cervicography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0008T		C	Upper gi endoscopy w/suture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0010T		C	Tb test, gamma interferon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0016T		C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0017T		C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0018T		C	Transcranial magnetic stimul	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T		I	Extracorp shock wave tx, ms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0020T		C	Extracorp shock wave tx, ft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0021T		C	Fetal oximetry, trnsvag/cerv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0023T		C	Phenotype drug test, hiv 1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0024T		C	Transcath cardiac reduction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0026T		C	Measure remnant lipoproteins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0027T		C	Endoscopic epidural lysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0028T		C	Dexa body composition study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0029T		C	Magnetic tx for incontinence	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0030T		C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0031T		C	Speculoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0032T		C	Speculoscopy w/direct sample	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0033T		C	Endovasc taa repr incl subcl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0034T		C	Endovasc taa repr w/o subcl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0035T		C	Insert endovasc prosth, taa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0036T		C	Endovasc prosth, taa, add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0037T		C	Artery transpose/endovas taa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0038T		C	Rad endovasc taa rpr w/cover	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0039T		C	Rad s/i, endovasc taa repair	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0040T		C	Rad s/i, endovasc taa prosth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0041T		C	Detect ur infect agnt w/cpas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0042T		C	Ct perfusion w/contrast, cbf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0043T		C	Co expired gas analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0044T		C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0045T		C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0046T		C	Cath lavage, mammary duct(s	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0047T		C	Cath lavage, mammary duct(s)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0049T		C	External circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	0.00	0.00	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0056T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0058T		C	Cryopreservation, ovary tiss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0059T		C	Cryopreservation, oocyte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0060T		C	Electrical impedance scan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0061T		C	Destruction of tumor, breast	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0062T		C	Rep intradisc annulus;1 lev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0063T		C	Rep intradisc annulus;>1lev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0064T		C	Spectroscop eval expired gas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0065T		C	Ocular photoscreen bilat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0066T		C	Ct colonography;screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0067T		C	Ct colonography;dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0068T		C	Interp/rept heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0069T		C	Analysis only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0070T		C	Interp only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0073T		A	Delivery, comp imrt	0.00	18.02	NA	0.13	18.15	NA	XXX
0074T		C	Online physician e/m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0075T		C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0076T		C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0077T		C	Cereb therm perfusion probe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0080T		C	Endovasc aort repr rad s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0081T		C	Endovasc visc extnsn s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0082T		C	Stereotactic rad delivery	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0083T		C	Stereotactic rad tx mngmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0084T		C	Temp prostate urethral stent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0085T		C	Breath test heart reject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0086T		C	L ventricle fill pressure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0087T		C	Sperm eval hyaluronan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0088T		C	Rf tongue base vol reduxn	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0500F		I	Initial prenatal care visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
0501F		I	Prenatal flow sheet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0502F		I	Subsequent prenatal care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0503F		I	Postpartum care visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1000F		I	Tobacco use, smoking, assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1001F		I	Tobacco use, non-smoking	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021		A	Fna w/o image	1.27	2.15	0.54	0.10	3.52	1.91	XXX
10022		A	Fna w/image	1.27	2.54	0.42	0.08	3.89	1.77	XXX
1002F		I	Assess anginal symptom/level	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10040		A	Acne surgery	1.18	1.01	0.79	0.06	2.25	2.03	010
10060		A	Drainage of skin abscess	1.17	1.21	0.93	0.12	2.50	2.22	010
10061		A	Drainage of skin abscess	2.40	1.82	1.50	0.26	4.48	4.16	010
10080		A	Drainage of pilonidal cyst	1.17	3.10	1.11	0.11	4.38	2.39	010
10081		A	Drainage of pilonidal cyst	2.45	4.07	1.50	0.25	6.77	4.20	010
10120		A	Remove foreign body	1.22	2.17	0.97	0.12	3.51	2.31	010
10121		A	Remove foreign body	2.69	3.51	1.78	0.32	6.52	4.79	010
10140		A	Drainage of hematoma/fluid	1.53	1.77	1.29	0.19	3.49	3.01	010
10160		A	Puncture drainage of lesion	1.20	1.60	1.08	0.14	2.94	2.42	010
10180		A	Complex drainage, wound	2.25	2.98	1.98	0.33	5.56	4.56	010
11000		A	Debride infected skin	0.60	0.58	0.22	0.07	1.25	0.89	000
11001		A	Debride infected skin add-on	0.30	0.23	0.11	0.03	0.56	0.44	ZZZ
11004		A	Debride genitalia & perineum	10.31	NA	3.90	0.67	NA	14.88	000
11005		A	Debride abdom wall	13.75	NA	5.56	0.96	NA	20.27	000
11006		A	Debride genit/per/abdom wall	12.61	NA	4.85	1.28	NA	18.74	000
11008		A	Remove mesh from abd wall	5.00	NA	2.02	0.61	NA	7.63	ZZZ
11010		A	Debride skin, fx	4.19	6.87	2.62	0.60	11.66	7.41	010
11011		A	Debride skin/muscle, fx	4.94	8.16	2.34	0.70	13.80	7.98	000
11012		A	Debride skin/muscle/bone, fx	6.87	12.10	3.84	1.12	20.09	11.83	000
11040		A	Debride skin, partial	0.50	0.52	0.21	0.06	1.08	0.77	000
11041		A	Debride skin, full	0.82	0.66	0.33	0.10	1.58	1.25	000
11042		A	Debride skin/tissue	1.12	0.97	0.44	0.13	2.22	1.69	000
11043		A	Debride tissue/muscle	2.38	3.38	2.59	0.29	6.05	5.26	010
11044		A	Debride tissue/muscle/bone	3.06	4.45	3.75	0.40	7.91	7.21	010
11055		R	Trim skin lesion	0.43	0.56	0.17	0.05	1.04	0.65	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.64	0.23	0.07	1.32	0.91	000
11057		R	Trim skin lesions, over 4	0.79	0.74	0.30	0.10	1.63	1.19	000
11100		A	Biopsy, skin lesion	0.81	1.25	0.37	0.04	2.10	1.22	000
11101		A	Biopsy, skin add-on	0.41	0.33	0.19	0.02	0.76	0.62	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
11200		A	Removal of skin tags	0.77	1.04	0.76	0.05	1.86	1.58	010
11201		A	Remove skin tags add-on	0.29	0.16	0.12	0.02	0.47	0.43	ZZZ
11300		A	Shave skin lesion	0.51	0.99	0.21	0.03	1.53	0.75	000
11301		A	Shave skin lesion	0.85	1.11	0.38	0.05	2.01	1.28	000
11302		A	Shave skin lesion	1.05	1.30	0.46	0.05	2.40	1.56	000
11303		A	Shave skin lesion	1.24	1.58	0.52	0.07	2.89	1.83	000
11305		A	Shave skin lesion	0.67	0.85	0.27	0.07	1.59	1.01	000
11306		A	Shave skin lesion	0.99	1.10	0.42	0.08	2.17	1.49	000
11307		A	Shave skin lesion	1.14	1.29	0.49	0.08	2.51	1.71	000
11308		A	Shave skin lesion	1.41	1.45	0.59	0.13	2.99	2.13	000
11310		A	Shave skin lesion	0.73	1.11	0.32	0.05	1.89	1.10	000
11311		A	Shave skin lesion	1.05	1.23	0.49	0.06	2.34	1.60	000
11312		A	Shave skin lesion	1.20	1.42	0.55	0.06	2.68	1.81	000
11313		A	Shave skin lesion	1.62	1.80	0.72	0.10	3.52	2.44	000
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.85	1.99	0.88	0.07	2.91	1.80	010
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.23	2.05	1.02	0.10	3.38	2.35	010
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.51	2.22	1.08	0.13	3.86	2.72	010
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.79	2.39	1.32	0.17	4.35	3.28	010
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.06	2.70	1.40	0.21	4.97	3.67	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	2.76	3.06	1.65	0.32	6.14	4.73	010
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	0.98	1.76	0.93	0.10	2.84	2.01	010
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.42	2.06	1.11	0.13	3.61	2.66	010
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.63	2.25	1.33	0.15	4.03	3.11	010
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.01	2.58	1.45	0.20	4.79	3.66	010
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.43	2.80	1.60	0.25	5.48	4.28	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	3.77	3.48	2.10	0.42	7.67	6.29	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.06	2.20	1.31	0.08	3.34	2.45	010
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.48	2.33	1.49	0.13	3.94	3.10	010
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.72	2.54	1.57	0.15	4.41	3.44	010
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.29	2.91	1.81	0.21	5.41	4.31	010
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.14	3.47	2.18	0.29	6.90	5.61	010
11446		A	Exc face-mm b9+marg > 4 cm	4.48	4.04	2.77	0.42	8.94	7.67	010
11450		A	Removal, sweat gland lesion	2.73	5.03	2.02	0.34	8.10	5.09	090
11451		A	Removal, sweat gland lesion	3.94	6.60	2.54	0.51	11.05	6.99	090
11462		A	Removal, sweat gland lesion	2.51	5.11	2.01	0.30	7.92	4.82	090
11463		A	Removal, sweat gland lesion	3.94	6.82	2.68	0.51	11.27	7.13	090
11470		A	Removal, sweat gland lesion	3.25	5.06	2.26	0.39	8.70	5.90	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
11471		A	Removal, sweat gland lesion	4.40	6.70	2.76	0.55	11.65	7.71	090
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.31	2.63	0.97	0.10	4.04	2.38	010
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	1.80	2.70	1.22	0.12	4.62	3.14	010
11602		A	Exc tr-ext mlg+marg 1.1-2 cm	1.95	2.82	1.26	0.13	4.90	3.34	010
11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.19	3.07	1.33	0.16	5.42	3.68	010
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	2.40	3.37	1.39	0.20	5.97	3.99	010
11606		A	Exc tr-ext mlg+marg > 4 cm	3.42	4.06	1.73	0.36	7.84	5.51	010
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.19	2.59	0.95	0.10	3.88	2.24	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	1.76	2.70	1.24	0.12	4.58	3.12	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	2.96	1.39	0.14	5.19	3.62	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	2.61	3.33	1.58	0.20	6.14	4.39	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.06	3.74	1.77	0.27	7.07	5.10	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.29	4.63	2.39	0.44	9.36	7.12	010
11640		A	Exc face-mm malig+marg 0.5 <	1.35	2.65	1.11	0.10	4.10	2.56	010
11641		A	Exc face-mm malig+marg 0.6-1	2.16	3.02	1.53	0.16	5.34	3.85	010
11642		A	Exc face-mm malig+marg 1.1-2	2.59	3.40	1.71	0.19	6.18	4.49	010
11643		A	Exc face-mm malig+marg 2.1-3	3.10	3.80	1.96	0.25	7.15	5.31	010
11644		A	Exc face-mm malig+marg 3.1-4	4.02	4.68	2.45	0.37	9.07	6.84	010
11646		A	Exc face-mm mlg+marg > 4 cm	5.94	5.75	3.47	0.60	12.29	10.01	010
11719		R	Trim nail(s)	0.17	0.25	0.07	0.02	0.44	0.26	000
11720		A	Debride nail, 1-5	0.32	0.34	0.12	0.04	0.70	0.48	000
11721		A	Debride nail, 6 or more	0.54	0.44	0.21	0.07	1.05	0.82	000
11730		A	Removal of nail plate	1.13	1.03	0.43	0.14	2.30	1.70	000
11732		A	Remove nail plate, add-on	0.57	0.44	0.22	0.07	1.08	0.86	ZZZ
11740		A	Drain blood from under nail	0.37	0.55	0.35	0.04	0.96	0.76	000
11750		A	Removal of nail bed	1.86	2.16	1.75	0.22	4.24	3.83	010
11752		A	Remove nail bed/finger tip	2.67	2.99	2.99	0.35	6.01	6.01	010
11755		A	Biopsy, nail unit	1.31	1.57	0.77	0.15	3.03	2.23	000
11760		A	Repair of nail bed	1.58	2.62	1.78	0.20	4.40	3.56	010
11762		A	Reconstruction of nail bed	2.89	2.88	2.34	0.36	6.13	5.59	010
11765		A	Excision of nail fold, toe	0.69	1.78	0.76	0.08	2.55	1.53	010
11770		A	Removal of pilonidal lesion	2.61	3.48	1.50	0.31	6.40	4.42	010
11771		A	Removal of pilonidal lesion	5.73	5.64	3.31	0.73	12.10	9.77	090
11772		A	Removal of pilonidal lesion	6.97	7.50	5.07	0.88	15.35	12.92	090
11900		A	Injection into skin lesions	0.52	0.65	0.21	0.03	1.20	0.76	000
11901		A	Added skin lesions injection	0.80	0.66	0.35	0.03	1.49	1.18	000
11920		R	Correct skin color defects	1.61	3.70	1.09	0.23	5.54	2.93	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
11921		R	Correct skin color defects	1.93	3.96	1.27	0.28	6.17	3.48	000
11922		R	Correct skin color defects	0.49	1.14	0.25	0.07	1.70	0.81	ZZZ
11950		R	Therapy for contour defects	0.84	1.14	0.39	0.06	2.04	1.29	000
11951		R	Therapy for contour defects	1.19	1.49	0.51	0.11	2.79	1.81	000
11952		R	Therapy for contour defects	1.69	1.85	0.68	0.16	3.70	2.53	000
11954		R	Therapy for contour defects	1.85	2.44	0.90	0.24	4.53	2.99	000
11960		A	Insert tissue expander(s)	9.07	NA	10.39	1.28	NA	20.74	090
11970		A	Replace tissue expander	7.05	NA	6.13	1.03	NA	14.21	090
11971		A	Remove tissue expander(s)	2.13	9.11	3.79	0.30	11.54	6.22	090
11975		N	Insert contraceptive cap	+1.48	1.42	0.57	0.17	3.07	2.22	XXX
11976		R	Removal of contraceptive cap	1.78	1.72	0.68	0.21	3.71	2.67	000
11977		N	Removal/reinsert contra cap	+3.30	2.27	1.26	0.37	5.94	4.93	XXX
11980		A	Implant hormone pellet(s)	1.48	1.08	0.54	0.13	2.69	2.15	000
11981		A	Insert drug implant device	1.48	1.70	0.68	0.12	3.30	2.28	XXX
11982		A	Remove drug implant device	1.78	1.94	0.83	0.17	3.89	2.78	XXX
11983		A	Remove/insert drug implant	3.30	2.28	1.47	0.24	5.82	5.01	XXX
12001		A	Repair superficial wound(s)	1.70	1.98	0.77	0.16	3.84	2.63	010
12002		A	Repair superficial wound(s)	1.86	2.04	0.90	0.18	4.08	2.94	010
12004		A	Repair superficial wound(s)	2.24	2.32	1.01	0.22	4.78	3.47	010
12005		A	Repair superficial wound(s)	2.86	2.82	1.20	0.28	5.96	4.34	010
12006		A	Repair superficial wound(s)	3.66	3.39	1.51	0.38	7.43	5.55	010
12007		A	Repair superficial wound(s)	4.11	3.82	1.81	0.44	8.37	6.36	010
12011		A	Repair superficial wound(s)	1.76	2.13	0.78	0.17	4.06	2.71	010
12013		A	Repair superficial wound(s)	1.99	2.27	0.93	0.19	4.45	3.11	010
12014		A	Repair superficial wound(s)	2.46	2.57	1.06	0.23	5.26	3.75	010
12015		A	Repair superficial wound(s)	3.19	3.13	1.25	0.30	6.62	4.74	010
12016		A	Repair superficial wound(s)	3.92	3.55	1.52	0.38	7.85	5.82	010
12017		A	Repair superficial wound(s)	4.70	NA	1.89	0.49	NA	7.08	010
12018		A	Repair superficial wound(s)	5.52	NA	2.25	0.61	NA	8.38	010
12020		A	Closure of split wound	2.62	3.82	1.92	0.30	6.74	4.84	010
12021		A	Closure of split wound	1.84	1.82	1.41	0.23	3.89	3.48	010
12031		A	Layer closure of wound(s)	2.15	2.28	0.96	0.18	4.61	3.29	010
12032		A	Layer closure of wound(s)	2.47	3.84	1.79	0.17	6.48	4.43	010
12034		A	Layer closure of wound(s)	2.92	3.19	1.45	0.26	6.37	4.63	010
12035		A	Layer closure of wound(s)	3.42	5.19	2.15	0.38	8.99	5.95	010
12036		A	Layer closure of wound(s)	4.04	5.55	2.54	0.52	10.11	7.10	010
12037		A	Layer closure of wound(s)	4.66	6.09	2.96	0.62	11.37	8.24	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
12041		A	Layer closure of wound(s)	2.37	2.54	1.13	0.20	5.11	3.70	010
12042		A	Layer closure of wound(s)	2.74	3.26	1.46	0.19	6.19	4.39	010
12044		A	Layer closure of wound(s)	3.14	3.21	1.60	0.29	6.64	5.03	010
12045		A	Layer closure of wound(s)	3.63	5.26	2.28	0.40	9.29	6.31	010
12046		A	Layer closure of wound(s)	4.24	6.50	2.75	0.51	11.25	7.50	010
12047		A	Layer closure of wound(s)	4.64	6.34	3.08	0.56	11.54	8.28	010
12051		A	Layer closure of wound(s)	2.47	3.27	1.45	0.20	5.94	4.12	010
12052		A	Layer closure of wound(s)	2.77	3.22	1.43	0.19	6.18	4.39	010
12053		A	Layer closure of wound(s)	3.12	3.24	1.53	0.24	6.60	4.89	010
12054		A	Layer closure of wound(s)	3.45	3.56	1.63	0.30	7.31	5.38	010
12055		A	Layer closure of wound(s)	4.42	4.48	2.12	0.45	9.35	6.99	010
12056		A	Layer closure of wound(s)	5.23	6.75	3.05	0.57	12.55	8.85	010
12057		A	Layer closure of wound(s)	5.95	6.13	3.75	0.54	12.62	10.24	010
13100		A	Repair of wound or lesion	3.12	4.05	2.30	0.27	7.44	5.69	010
13101		A	Repair of wound or lesion	3.91	4.66	2.68	0.28	8.85	6.87	010
13102		A	Repair wound/lesion add-on	1.24	1.17	0.57	0.13	2.54	1.94	ZZZ
13120		A	Repair of wound or lesion	3.30	4.14	2.34	0.28	7.72	5.92	010
13121		A	Repair of wound or lesion	4.32	4.85	2.79	0.29	9.46	7.40	010
13122		A	Repair wound/lesion add-on	1.44	1.51	0.63	0.15	3.10	2.22	ZZZ
13131		A	Repair of wound or lesion	3.78	4.36	2.68	0.28	8.42	6.74	010
13132		A	Repair of wound or lesion	5.94	5.90	4.16	0.35	12.19	10.45	010
13133		A	Repair wound/lesion add-on	2.19	1.66	1.03	0.18	4.03	3.40	ZZZ
13150		A	Repair of wound or lesion	3.80	4.87	2.76	0.34	9.01	6.90	010
13151		A	Repair of wound or lesion	4.44	4.80	3.14	0.32	9.56	7.90	010
13152		A	Repair of wound or lesion	6.32	6.03	4.04	0.42	12.77	10.78	010
13153		A	Repair wound/lesion add-on	2.38	1.93	1.14	0.25	4.56	3.77	ZZZ
13160		A	Late closure of wound	10.46	NA	7.16	1.49	NA	19.11	090
14000		A	Skin tissue rearrangement	5.88	7.85	5.46	0.59	14.32	11.93	090
14001		A	Skin tissue rearrangement	8.46	9.41	7.07	0.83	18.70	16.36	090
14020		A	Skin tissue rearrangement	6.58	8.61	6.53	0.64	15.83	13.75	090
14021		A	Skin tissue rearrangement	10.04	9.98	8.28	0.83	20.85	19.15	090
14040		A	Skin tissue rearrangement	7.86	8.80	7.20	0.65	17.31	15.71	090
14041		A	Skin tissue rearrangement	11.47	10.59	8.67	0.76	22.82	20.90	090
14060		A	Skin tissue rearrangement	8.49	8.78	7.43	0.68	17.95	16.60	090
14061		A	Skin tissue rearrangement	12.27	11.60	9.50	0.77	24.64	22.54	090
14300		A	Skin tissue rearrangement	11.74	11.13	9.17	1.16	24.03	22.07	090
14350		A	Skin tissue rearrangement	9.60	NA	7.14	1.32	NA	18.06	090

3 +Indicates RVUs are not used for Medicare payment.