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In addition, because of the many organizations and terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

AMA American Medical Association  
 BBA Balanced Budget Act of 1997  
 BBRA Balanced Budget Refinement Act of 1999  
 CF Conversion factor  
 CFR Code of Federal Regulations  
 CMS Centers for Medicare & Medicaid Services  
 CNS Clinical Nurse Specialist  
 CPT [Physicians'] Current Procedural Terminology [4th Edition, 2002, copyrighted by the American Medical Association]  
 CPEP Clinical Practice Expert Panel  
 CRNA Certified Registered Nurse Anesthetist  
 E/M Evaluation and management  
 FMR Fair market rental  
 GAF Geographic adjustment factor  
 GPCI Geographic practice cost index  
 HCPCS Healthcare Common Procedure Coding System  
 HHA Home health agency  
 HHS [Department of] Health and Human Services  
 IDTFs Independent Diagnostic Testing Facilities  
 MCM Medicare Carrier Manual  
 MedPAC Medicare Payment Advisory Commission  
 MEI Medicare Economic Index  
 MGMA Medical Group Management Association  
 MPFS Medicare Physician Fee Schedule  
 MSA Metropolitan Statistical Area  
 NAMCS National Ambulatory Medical Care Survey  
 PC Professional component  
 PEAC Practice Expense Advisory Committee  
 PPS Prospective payment system  
 RUC [AMA's Specialty Society] Relative [Value] Update Committee  
 RVU Relative value unit  
 SGR Sustainable growth rate  
 SMS [AMA's] Socioeconomic Monitoring System  
 SNF Skilled Nursing Facility

TC Technical component

## I. Background

### A. Legislative History

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), "Payment for Physicians' Services." This section provides for three major elements: (1) A fee schedule for the payment of physicians' services; (2) limits on the amounts that nonparticipating physicians can charge beneficiaries; and (3) a sustainable growth rate for the rates of increase in Medicare expenditures for physicians' services. The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) based on the resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense, and malpractice expense. Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs may not cause total physician fee schedule payments to differ by more than \$20 million from what they would have been had the adjustments not been made. If adjustments to RVUs cause expenditures to change by more than \$20 million, we must make adjustments to ensure that they do not increase or decrease by more than \$20 million.

### B. Published Changes to the Fee Schedule

In the July 2000 proposed rule, (65 FR 44177), we listed all of the final rules published through November 1999. In the August 2001 proposed rule (66 FR 40372) we discussed the November 2000 final rule relating to the updates to the RVUs and revisions to payment policies under the physician fee schedule.

In the November 2001 final rule with comment period (66 FR 55246), we made revisions to resource-based practice expense RVUs; services and supplies incident to a physician's professional service; anesthesia base unit variations; recognition of CPT tracking codes; and nurse practitioners, physician assistants, and clinical nurse specialists performing screening sigmoidoscopies. We also addressed comments received on the June 8, 2001 proposed notice (66 FR 31028) for the 5-year review of work RVUs and finalized these work RVUs. In addition, we acknowledged comments received in response to a discussion of modifier-62, which is used to report the work of co-surgeons. The November 2001 final rule also updated the list of services that are subject to the physician self-referral

prohibitions in order to reflect CPT and Healthcare Common Procedure Coding System (HCPCS) code changes that were effective January 1, 2002. All these revisions ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. This final rule also conformed our regulations to reflect statutory provisions of Medicare, Medicaid, and State Child Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554) (BIPA) concerning: The mammography screening benefit; biennial screening pelvic examinations for certain beneficiaries; expanded coverage for screening colonoscopies to all beneficiaries; provided for annual glaucoma screenings for high-risk beneficiaries; established coverage for medical nutrition therapy services for certain beneficiaries; expanded payment for telehealth services; required certain Indian Health Service providers to be paid for some services under the physician fee schedule; and revised the payment for certain physician pathology services.

In the December 31, 2002 final rule with comment period (67 FR 79966), we refined resource-based practice expense RVUs and made other changes to Medicare Part B policy. These included: The pricing of the technical component for positron emission tomography (PET) scans, Medicare qualifications for clinical nurse specialists, a process to add or delete services to the definition of telehealth, the definition for ZZZ global periods, global period for surface radiation, and application of endoscopic reduction rules for certain codes. In addition, this rule: Updated the codes subject to physician self-referral prohibitions, expanded the definition of a screening fecal-occult blood test, and modified our regulations to expand coverage for additional colorectal cancer screening tests through our national coverage determination process. We also made revisions to the sustainable growth rate, the anesthesia conversion factor (CF), and the work values for some gastroenterologic services. We finalized the CY 2002 interim RVUs and assigned interim RVUs for new and revised procedure codes for calendar year CY 2003, clarified the enrollment of therapists in private practice and the policy regarding services and supplies incident to a physician's professional services, and made technical changes to the definition of outpatient rehabilitation services.

This final rule also revised the regulations at 42 CFR 485.618 to allow registered nurses (RNs) to provide