

and adolescents. It is caused by an insulin resistance whose etiology is multiple and not totally understood. Gestational diabetes is any degree of glucose intolerance with onset or first recognition during pregnancy. The diagnostic criterion for a diagnosis of diabetes for a fasting glucose intolerance test is greater than or equal to 126 mg/dL.

C. Outpatient Therapy Services Performed "Incident To" Physicians' Services—Discussion Only

In almost all settings, our policy provides that outpatient therapy services can be delivered only by physical therapists, occupational therapists, physical therapy assistants, occupational therapy assistants, and speech and language pathologists as defined by our regulations at § 484.4. While there are currently no national standards for qualifications of individuals providing outpatient therapy services incident to physicians' services, we believe that standards similar to those in § 484.4 are appropriate. Section 1862(a)(20) of the Act requires that any therapy services furnished incident to a physician's professional services must meet the standards and conditions that would apply to such therapy services if they were furnished by a therapist, with the exception of the licensing requirement.

The OIG conducted a study in March of 1994 (OEI-02-09-00590) which revealed that 78 percent of "incident to" physical therapy services did represent therapy services covered under Medicare (that is, reasonable and necessary as defined in section 1862(a)(1)(A) of the Act). The study also questioned the training of staff providing these services. Also, in 2002 we contracted for a report on the utilization of therapy services. The text of that report is available at www.cms.hhs.gov/medlearn/therapy under Research Tools for Specific Therapy Topics, DynCorp Report—Outpatient Therapy Utilization September 2002. The study found that 25 percent of the beneficiaries in 2000 were treated in the offices of physicians and nonphysician practitioners. There is currently no process to ensure the quality of the services provided in those settings.

The pending implementation of financial limitations on outpatient therapy services emphasizes the need to define the qualifications of those providing therapy services. The limited therapy services covered by Medicare must be provided by people who meet qualifications needed to render skilled services.

In order to conform to section 1862(a)(20) of the Act, we are considering adopting the existing qualification and training standards (with the exception of licensure) in § 484.4 for individuals providing therapy services independently and incident to physicians' services. We are not proposing a change at this time, but are interested in receiving comments from the public, particularly physicians and staff who would be affected, on adoption of the existing standards in § 484.4, to services of independent therapists and "incident to" services as well as alternatives that we might use to ensure that qualified staff are providing "incident to" therapy services. These comments would assist us in the development of any future proposal concerning this issue.

D. Status of Anesthesia Work and Five-Year Review

In the December 2002 final rule, we modestly increased the work of anesthesia services. These changes were based on the analysis submitted by the RUC of its review of the work of 19 high-volume anesthesia codes. The RUC had provided us with its analysis but did not furnish us with a definitive recommendation. The increase in anesthesia work resulted in an increase in the national anesthesia conversion factor. (We increased the physician work component of the anesthesia conversion factor by 2.10 percent to reflect a 9.13 percent increase in anesthesia work applied to 23 percent of anesthesia allowed charges represented by the 19 codes. We applied a 1.6 percent increase to the anesthesia CF.)

The American Society of Anesthesiologists expressed concerns about the completeness of the review of anesthesia under the five-year review, and, in February 2003, we asked the RUC to continue its review of anesthesia work values; we expected to develop a final recommendation for a change in the anesthesia CF involving all anesthesia codes. We asked that the RUC complete this analysis in 2003. The RUC is considering our request and will respond to us about what action they plan to take on this issue.

E. Payment Policies for Anesthesia Services

Currently there are different payment policies for teaching anesthesiologists and teaching certified registered nurse anesthetists (CRNAs). We are seeking comments on the appropriateness of applying the CRNA teaching/resident policy to teaching anesthesiologists.

F. Technical Correction

CPT Code 96155 (Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)).

This code describes a visit with a patient's family without the patient being present and was first included in the November 1, 2001 final rule. It was incorrectly listed as an active code for which payment could be made under the physician fee schedule. Our longstanding payment policy is that we do not pay for visits with family where the patient is not present. Payment for such visits is included in the pre- and post-service work of a visit where the patient is present. Consistent with this policy, this code is non-payable under the physician fee schedule.

IV. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

V. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, 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, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

VI. 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 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 proposed rules with economically significant effects (that is, a proposed rule that would have an annual effect on the economy of \$100 million or more in any