

\$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 Physicians' Current Procedural Terminology (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; annual glaucoma screenings for high-risk beneficiaries; coverage for medical nutrition therapy services for certain beneficiaries; expanded payment for telehealth services; payment for certain Indian Health Service for some services under the physician fee schedule; and revision of 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 SGR, the anesthesia conversion factor (CF), and the work values for some gastroenterologic services. We finalized the calendar year (CY) 2002 interim RVUs and assigned interim RVUs for new and revised procedure codes for 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 § 485.618 to allow registered nurses (RNs) to provide emergency care in certain critical access hospitals (CAHs) in frontier areas (an area with fewer than six residents per square mile) or remote locations (locations designated in a State's rural health plan that we have approved).

As required by statute this final rule also announced that the physician fee schedule update for CY 2003 was -4.4 percent, the initial estimate of the SGR for CY 2003 was 7.6 percent, and the CF for CY 2003 was \$34.5920, effective March 1, 2003. However, on February 28, 2003 (68 FR 9567), after enactment of the Consolidated Appropriations Resolution of 2003 (Pub. L. 108-7), we published a final rule that revised the estimates used to establish the SGRs for fiscal years 1998 and 1999 and announced a 1.6 percent increase in the CY 2003 physician fee schedule CF for March 1 to December 31, 2003. The CF from March 1 to December 31, 2003 is \$36.7856 and the anesthesia CF for this period is \$17.05. All other provisions of the December 31, 2002 final rule were unchanged by the rule published February 28, 2003.

#### *C. Components of the Fee Schedule Payment Amounts*

Under the formula set forth in section 1848(b)(1) of the Act, the payment

amount for each service paid under the physician fee schedule is the product of three factors—(1) a nationally uniform relative value for the service; (2) a geographic adjustment factor (GAF) for each physician fee schedule area; and (3) a nationally uniform conversion factor (CF) for the service. The CF converts the relative values into payment amounts.

For each physician fee schedule service, there are three relative values—(1) an RVU for physician work; (2) an RVU for practice expense; and (3) an RVU for malpractice expense. For each of these components of the fee schedule, there is a geographic practice cost index (GPCI) for each fee schedule area. The GPCIs reflect the relative costs of practice expenses, malpractice insurance, and physician work in an area compared to the national average for each component.

The general formula for calculating the Medicare fee schedule amount for a given service in a given fee schedule area can be expressed as:

$$\text{Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU practice expense} \times \text{GPCI practice expense}) + (\text{RVU malpractice} \times \text{GPCI malpractice})] \times \text{CF}$$

The CF for CY 2004 appears in section IX. The RVUs for CY 2004 are in Addendum B. The GPCIs for CY 2004 can be found in Addendum D.

Section 1848(e) of the Act requires us to develop GAFs for all physician fee schedule areas. The total GAF for a fee schedule area is equal to a weighted average of the individual GPCIs for each of the three components of the service. In accordance with the statute, however, the GAF for the physician's work reflects one-quarter of the relative cost of physician's work compared to the national average.

#### *D. Development of the Relative Value System*

##### *1. Work Relative Value Units (RVUs)*

Approximately 7,500 codes represent services included in the physician fee schedule. The work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original work RVUs for most codes in a cooperative agreement with us. In constructing the vignettes for the original RVUs, Harvard worked with expert panels of physicians and obtained input from physicians from numerous specialties.

The RVUs for radiology services were based on the American College of Radiology (ACR) relative value scale,