

laboratory measurements used to determine the presence of diabetes should be expanded. The definition provided by AACE appears to meet the clinical concerns of the medical community and our concerns that no individuals have their treatments delayed unduly if they have obvious symptoms of uncontrolled diabetes. Therefore, we are adopting their clinical definition. We will also broaden our general language to include diabetes of other types. Our final language will be, "Diabetes is 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 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes." We will also make a conforming amendment to 410.130 for MNT. However, we are constrained from covering MNT for anyone who is not diagnosed with diabetes by the section 1861(s)(2)(V) of the Act that limits coverage of MNT to beneficiaries with diabetes or renal disease.

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

In almost all settings, our regulations specify that outpatient therapy services can be delivered only by qualified physical therapists, occupational therapists, physical therapy assistants, occupational therapy assistants, and speech-language pathologists as defined by § 484.4. 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. 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. In the proposed rule, we stated that 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. While we did not propose a change at this time, we requested comments from the public, particularly physicians and staff who would be affected, on adoption of the

existing standards in § 484.4, for services of independent therapists and "incident to" services, as well as comments regarding alternatives that we might use to ensure that qualified staff are providing "incident to" therapy services.

We received comments from major therapy organizations and individual therapists representing therapy services, physician organizations and individual physicians and associations and individuals representing other health care professionals, such as athletic trainers, kinesiotherapists and exercise physiologists. A wide spectrum of views was expressed by these commenters. Commenters representing therapists were supportive of establishing consistent training standards in all settings, while physicians favored reliance on the individual physician for quality control. The non-therapist health care providers were concerned about their role in providing therapy services and cardiac rehabilitation and pulmonary service providers were concerned that their services might be affected.

We will review and consider these comments as we determine whether to make a future proposal. Meanwhile, contractors may continue to develop local medical review policies that are consistent with the statute, applying to physical therapy, occupational therapy and speech-language pathology services the same standards and conditions that would apply to such therapy services if they were furnished by an independent therapist, with the exception of the licensing requirement.

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. As a result of this increase, we applied a 1.6 percent increase to the anesthesia CF.) The American Society of Anesthesiologists expressed concern about the completeness of the review of anesthesia codes under the five-year

review. Therefore, in February 2003 we asked the RUC to continue its review of anesthesia work values so that we could develop a final recommendation for a change in the anesthesia CF involving all anesthesia codes. In the proposed rule we stated we were waiting on the RUC's response to our request.

The RUC has spent a considerable amount of effort of studying this issue. The RUC's anesthesia workgroups consisted of a range of physician specialists, including various surgical specialists, who have knowledge about the anesthesia services studied. As a result of their review, the RUC approved and presented the following recommendations to CMS:

1. The RUC position is that the 5-year review has been completed.

2. The RUC anesthesia workgroup analysis only applies to the 19 anesthesia codes and associated 19 surgical codes.

3. The Workgroup recommendations to the RUC stated that there are structural differences between the anesthesia coding system and the remainder of the physician coding system, which contributes to the difficulties in making extrapolations to the entire set of anesthesia services. Among other things, the workgroups and the RUC were concerned that the anesthesia codes cover too large a number of surgical codes making it necessary to examine surgical codes within the anesthesia code, and the 19 selected anesthesia codes may not be the most representative codes.

The ASA disagrees with the RUC's recommendations and asked that we extrapolate from the 19 surveyed procedures to all anesthesia codes.

Decision

When we developed the 2002 final physician fee schedule rule on the second five-year review, one of our concerns was that the RUC's initial findings were not presented as specific recommendations. We wanted to pursue approaches consistent with RUC recommendations. Therefore, in early 2003, we asked the RUC to more clearly present their recommendations.

Based on our review of the history and analysis of this issue and the final recommendation of the RUC, we have decided not to extrapolate from the surveyed procedures to the entire universe of anesthesia procedures; we will make no further adjustments to anesthesia work under the second five-year review.