

The RUC recommendations on the practice expense inputs for the new and revised 2004 codes were submitted to us as interim recommendations. We, therefore, consider that these recommendations are still subject to further refinement by the PEAC, or by us, if it is determined that such future review is needed. We may also revisit these inputs in light of future decisions of the PEAC regarding supply and equipment packages and standardized approaches to pre- and post-service clinical staff times.

We have accepted, in the interim, almost all of the practice expense recommendations submitted by the RUC for the codes listed in the following table titled "AMA RUC and HCPAC RVU Recommendations and CMS Decisions for New and Revised 2004 CPT Codes."

We made the following minor changes to the inputs where relevant:

- We deleted the 3-minute phone calls in the post service period to conform to our established standard for all codes with 10 and 90-day global periods.
- We also deleted equipment when individual items did not meet the minimum \$500 requirement.
- We deleted certain equipment items that represent indirect, rather than direct costs, including lead shielding, lead lined radioactive waste box and lead-lined sharps box.
- We deleted the L-Block table shield because it is included in the price and description of the dose calibrator, another CPEP equipment item.
- We made minor changes to clinical labor and supplies, for several central venous access (CVA) codes in order to bring uniformity to this new family of codes.
- We assigned, on an interim basis, the clinical labor RN designation for CPT code 95991, physician administered refilling and maintenance of spinal or brain implantable pump, until the PEAC has an opportunity to review the necessity for this clinical assignment.

## V. Update to the Codes for Physician Self-Referral Prohibition

### A. Background

On January 4, 2001 we published in the **Federal Register** a final rule with comment period, "Medicare and Medicaid Programs; Physicians Referrals to Health Care Entities With Which They Have Financial Relationships" (66 FR 856). That final rule incorporated into regulations the provisions in paragraphs (a), (b) and (h) of section 1877 of the Act. Section 1877

of the Act prohibits a physician from referring a Medicare beneficiary for certain "designated health services" to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. In the final rule, we published an attachment listing all of the CPT and HCPCS codes that defined the entire scope of the following designated health services for purposes of section 1877 of the Act: clinical laboratory services; physical therapy services (including speech-language pathology services); occupational therapy services; radiology and certain other imaging services; and radiation therapy services and supplies.

In the January 2001 final rule, we stated that we would update the list of codes used to define these designated health services (the "Code List") in an addendum to the annual physician fee schedule final rule. The purpose of the update is to conform the Code List to the most recent publications of CPT and HCPCS codes. The last update of the Code List was included in the December 31, 2002 physician fee schedule final rule in Addendum E and was subsequently corrected in a notice that was published in the **Federal Register** (68 FR 32400) on May 30, 2003.

The updated all-inclusive Code List effective January 1, 2004 is presented in Addendum F in this final rule. We intend to publish annually the all-inclusive Code List in an addendum to the physician fee schedule final rule. The updated all-inclusive Code List will also be available on our Web site at <http://www.cms.hhs.gov/medlearn/refphys.asp>.

### B. Response to Comments

We received public comments on three issues relating to the most recent Code List. The comments and our responses are stated below.

*Comment:* One commenter noted that we added three new "Q" codes (Q3021, Q3022, and Q3023) for hepatitis B vaccines. Program Memorandum AB-02-185 issued on December 31, 2002 deleted these HCPCS codes. However, the Program Memorandum also reactivated the following CPT codes for hepatitis B vaccine: 90740, 90743, 90744, 90746 and 90747.

*Response:* The commenter is correct. We erred in adding the "Q" codes to the list of services that may qualify for an exception under 42 CFR 411.355(h) concerning exceptions for preventive screening tests, immunizations, and vaccines. This was corrected in the correction notice published on May 30, 2003 (68 FR 32400).

*Comment:* Some commenters objected to the addition of CPT code 0020T (Extracorporeal shock wave therapy; involving plantar fascia) to the list of physical therapy services for purposes of the physician self-referral prohibition. The commenters stated that CPT 0020T is currently a physician service involving anesthesia and therefore, should not be characterized as a physical therapy service.

*Response:* We agree with the commenters and have removed CPT code 0020T from the list of designated health services. Further discussion of this comment and response is included in section IV.C.2 of this preamble concerning the HCPCS codes G0279 and G0280 relating to extracorporeal shock wave therapy.

*Comment:* One commenter noted that the annual Code List update does not include codes for the following designated health services: Durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. The commenter recommended that we include the CPT and HCPCS codes for these designated health services in the annual update and in the quarterly updated Microsoft Excel spreadsheet of RVU values, global periods and supervision levels for Medicare covered-services posted on the CMS Web site. Alternatively, the commenter requested that we clarify that the Code List is not exhaustive and indicate where providers can obtain more information on the remaining categories.

*Response:* As explained in the January 4, 2001 final rule with comment (66 FR 923), we believe that the regulatory definitions of the designated health services at issue are sufficiently clear to permit entities and physicians to identify them readily. Moreover, some of these designated health services are not amenable to definition solely through codes. Regardless, to define these services through codes or to change the frequency of the Code List update would require a change in the text of the regulatory definitions for the various designated health services found in § 411.351. The purpose of this Code List is simply to make those ministerial changes necessary to conform the Code List to the current CPT and HCPCS code publications. Making substantive changes to the regulatory definitions is beyond the scope of this update and cannot be accomplished without first proposing