

TABLE 23

2003 Conversion Factor .....	\$36.7856
2004 Update .....	0.9551
2004 Conversion Factor .....	\$35.1339

#### Anesthesia Fee Schedule Conversion Factor

Anesthesia services do not have RVUs like other physician fee schedule services. Therefore, we account for any necessary RVU adjustments through an adjustment to the anesthesia fee schedule CF. We are adjusting the anesthesia CF to reflect the RVUs adjustments being made to all other physician fee schedule services to match the revised MEI weights. The 2003 anesthesia CF is \$17.05. Physician work represents 79.02 percent of the anesthesia CF (0.7902). We are decreasing this portion of the anesthesia CF by 0.57 percent (0.9943). Practice expenses represent 13.75 percent (0.1375) of the anesthesia CF. We are reducing this portion of the anesthesia conversion factor by 0.77 percent (0.9923) for the adjustment to match the RVUs with the MEI weights. In addition, we are increasing the practice expense portion of the anesthesia CF by 0.18 percent (1.0018) for changes to anesthesia practice expenses resulting from the refinement of practice expense RVUs. Taken together, we are reducing the practice expense portion of the anesthesia fee schedule CF by 0.59 percent ( $0.9923 \times 1.0018 = 0.9941$ ). Professional liability insurance represents 7.23 percent (0.0723) of the anesthesia CF. We are increasing this portion of the anesthesia CF by 19.86 percent (1.1986). Taken together, the adjustments to the work, practice expense and malpractice portions of the anesthesia CF result in a total adjustment of 1.090 percent ( $0.7903 \times 0.9943 + ((0.1347 \times 0.9941) + (0.0723 \times 1.1986) = 1.0090$ ). To determine the anesthesia fee schedule CF for 2004, we used the following figures:

TABLE 24

2003 Anesthesia Conversion Factor .....	\$17.0522
Adjustments to match MEI weights and practice expense factor .....	1.0090
2004 Update .....	0.9551
2004 Anesthesia Conversion Factor .....	\$16.4339

#### IX. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for

telehealth services provided from October 1, 2001, through December 31 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2004 is 2.9 percent.

Therefore, for CY 2004, the payment amount for HCPCS code "Q3014, telehealth originating site facility fee" is 80 percent of the lesser of the actual charge or \$21.20.

The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown below.

TABLE 25

Facility fee	MEI increase (percent)	Period
\$20.00 .....	N/A	10/01/2001–12/31/2002
\$20.60 .....	3.0	01/01/2003–12/31/2003
\$21.20 .....	2.9	01/01/2004–12/31/2004

#### X. Provisions of the Final Regulations

This final rule with comment period adopts the provisions of the August 2003 proposed rule except as noted elsewhere in the preamble. The following is a highlight of the changes made from the proposed rule.

For geographic practice cost indices, based upon the volatility of the premium data collected, our review of the comments received on the August 15, 2003 proposed rule, and our review of malpractice GPCIs, we have modified some of our GPCI calculations and assumptions. We reduced the overall impact associated with revision to the malpractice GPCIs by a factor of 50 percent to mitigate for the volatility of the data. As directed by the statute, we will implement half of this change in the first year (CY 2004) and half of this change in the second year (CY 2005).

For the creation G codes for monitoring heart rhythms issue, based on concerns raised by commenters, we will not proceed with the proposed HCPCS codes because we want to ensure that any HCPCS codes developed, encompass the various technologies that are being utilized for such monitoring.

For changes in payments to physicians managing patients on dialysis, we are moving forward with our proposals and we are adjusting the payment rates for the established G codes. In addition we are adding

additional codes to address the concerns raised about home dialysis.

For the definition of diabetes for diabetes self-management training we adopted the AACE clinical definition. We also expanded our general language to include other types of diabetes.

For excision of benign and malignant lesions, we are not moving forward with our proposal, however, we will maintain the 2003 work RVUs as interim values for 2004 to allow opportunity for the specialty to resurvey these services.

For payment policies for anesthesia services we have decided to allow teaching anesthesiologists to bill, similarly to teaching CRNAs, for their involvement in two concurrent cases involving residents.

#### XI. 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 (44 U.S.C. 35).

#### XII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, 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.

#### XIII. 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 final rules with economically significant effects (that is, a final rule that would have an annual effect on the economy of \$100