

TABLE 29.—REVISED GEOGRAPHIC ADJUSTMENT FACTORS FROM FINAL RULE—Continued

Carrier No.	Locality No.	Locality name	2003 GAF	2004 GAF	Percent difference
00900 .....	28	Fort Worth, TX .....	0.983	0.985	0.2
00900 .....	15	Galveston, TX .....	0.991	0.992	0.1
00900 .....	18	Houston, TX .....	1.025	1.026	0.1
00900 .....	99	Rest of Texas .....	0.929	0.932	0.2
00910 .....	09	Utah .....	0.951	0.948	-0.2
31145 .....	50	Vermont .....	0.965	0.962	-0.3
00973 .....	50	Virgin Islands .....	0.991	0.992	0.1
00904 .....	00	Virginia .....	0.949	0.947	-0.2
00836 .....	02	Seattle (King Cnty), WA .....	1.038	1.038	0.0
00836 .....	99	Rest of Washington .....	0.971	0.970	-0.1
00884 .....	16	West Virginia .....	0.929	0.933	0.5
00951 .....	00	Wisconsin .....	0.958	0.954	-0.4
00825 .....	21	Wyoming .....	0.938	0.936	-0.2

### C. Tracking Codes

We are adopting a policy that will allow CMS to create national payment policy and determine national payment amounts for CPT tracking codes regardless of whether a national coverage determination for a specific service has been made. Our policy will have no effect on Medicare expenditures but will allow for more flexibility in determining payment rates for new services.

### D. G Codes for Managing Dialysis Patients

As previously discussed in section II.D., we have reviewed our current payment policy for the monthly dialysis capitation payment in response to concerns that have been raised over whether our payment policy is consistent with current medical practice. We are establishing new G codes for these services and are aligning Medicare's payment to recognize the higher amount of physician work associated with more frequent face-to-face visits. Aggregated Medicare payments to physicians for treating dialysis patients will not be increased or decreased by the establishment of these new procedure codes. Relative to payment based on the current CPT codes, Medicare payments to physicians for providing fewer than four visits per month will decrease. If the physician provides four or more visits per month, payment will increase. The net effect of these payment changes will not increase or decrease aggregate Medicare payment for physician services provided to dialysis patients.

### E. Rebasings and Revising the MEI

Section IV.B. of this final rule discusses rebasing and revising the MEI for the CY 2004 physician fee schedule. Substituting the 2000 MEI weights in place of the 1996 weights increases the MEI by 0.1 percent for 2004. After 2004,

the MEI in some years is likely to be unaffected by using more recent year weights while other years may have slightly higher increases (between 0.1 to 0.2 percentage points).

### F. Definition of Diabetes for Diabetes Self-Management Training

In section III.A., we revised the definition of diabetes for purposes of the Outpatient Diabetes Self-Management Training benefit and are using this definition to determine beneficiary eligibility for Medical Nutrition Therapy when the beneficiary has a diagnosis of diabetes. The streamlining of the beneficiary eligibility requirements for Outpatient Diabetes Self-Management Training will reduce administrative burden for the referring physician or qualified non-physician practitioner and for the accredited Outpatient Diabetes Self-Management Training programs by simplifying documentation requirements and eliminating the need for reconsiderations and appeals to clarify that the requirements have been met. As indicated in the February 28, 2003 **Federal Register** (68 FR 9572), we incorporated an adjustment to the SGR consistent with our original estimates of expenditures associated with this new benefit. Our experience is that expenditures have been less than originally estimated. We expect that simplifying administrative requirements associated with this new benefit will make it more likely that expenditures for diabetes self-management training will be consistent with original estimates and there will be no increase in Medicare expenditures from making these modifications.

### G. Payment Policies for Anesthesia Services

In section III.D. of this final rule, we discussed Medicare payment for anesthesia services involving anesthesiologists and residents.

Effective January 1, 2004, we are revising our teaching anesthesia rules to allow teaching anesthesiologists to bill, similar to teaching CRNAs, for their involvement in two concurrent cases with residents. The policy change will allow anesthesiologists to be paid either under the rules for medical direction or the same way that teaching CRNAs are paid for two concurrent cases. We are uncertain how the practice arrangements of teaching anesthesiologists will change as a result of this new policy. We believe that most teaching anesthesiologists will continue to function under the medical direction practice model for concurrent cases involving residents. Therefore, we believe there will be minimal change in Medicare program expenditures as a result of this change.

### H. Alternatives Considered

This proposed rule contains a range of policies. The preamble identifies those policies when discretion has been exercised and presents rationale for our decisions, including a presentation of nonselected options.

### I. Impact on Beneficiaries

Although changes in physicians' payments were large when the physician fee schedule was implemented in 1992, we detected no problems with beneficiary access to care. While it has been suggested that the negative update for 2004 may affect beneficiary access to care, we note that the formula to determine this update is set by statute and this regulation cannot, and does not, change it. Nevertheless, we remain concerned about the issue and will continue to study the issue to the best of our ability with available resources.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.