

List of Subjects**42 CFR Part 410**

Health facilities, Health professions,
Kidney diseases,

42 CFR Part 414

Administrative practice and
procedure, Health facilities, Health
professions, Kidney diseases, Medicare,
Reporting and recordkeeping
requirements, Rural areas, X-rays.

■ For the reasons set forth in the
preamble, the Centers for Medicare &
Medicaid Services amends 42 CFR
chapter IV as follows:

**PART 410—SUPPLEMENTARY
MEDICAL INSURANCE (SMI)
BENEFITS**

■ 1. The authority citation for part 410
continues to read as follows:

Authority: Secs. 1102 and 1871 of the
Social Security Act (42 U.S.C. 1302
and 1395hh).

■ 2. Section 410.130 is amended by
revising the definition of “Diabetes” to
read as follows:

§ 410.130 Definitions

* * * * *

Diabetes means 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.

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■ 3. Section 410.140 is amended by
adding the definition of “Diabetes” in
alphabetical order to read as follows:

§ 410.140 Definitions

* * * * *

Diabetes means 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.

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■ 4. Section 410.141 is amended by
revising paragraph (d) to read as follows:

**§ 410.141 Outpatient diabetes self-
management training.**

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(d) Beneficiaries who may be covered.
Medicare Part B covers outpatient
diabetes self-management training for a
beneficiary who has been diagnosed
with diabetes.

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**PART 414—PAYMENT FOR PART B
MEDICAL AND OTHER HEALTH
SERVICES**

■ 1. The authority citation for part 414
continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1)
of the Social Security Act (42 U.S.C. 1302,
1395hh, and 1395rr(b)(1)).

■ 2. Section 414.22(b)(6)(iii) is revised to
read as follows:

§ 414.22 Relative value units (RVUs).

* * * * *

(b) * * *

(6) * * *

(iii) CMS will consider for use in
determining practice expense RVUs for
the physician fee schedule survey data
and related materials submitted to CMS
by March 1, 2004 to determine CY 2005
practice expense RVUs and by March 1,
2005 to determine CY 2006 practice
expense RVUs.

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■ 3. Section 414.46 is amended to—

■ a. Redesignate paragraphs (e) through
(g) as paragraphs (f) through (h),
respectively.

■ b. Add new paragraph (e).

■ The addition reads as follows:

**§ 414.46 Additional rules for payment of
anesthesia services.**

* * * * *

(e) *Physicians involved with two
concurrent cases with residents.* The
physician can bill base units and time
units based on the amount of time the
physician is actually present with the
resident during each of two concurrent
cases furnished on or after January 1,
2004.

(1) To bill the base units, the
physician must be present with the
resident during the pre- and post-
anesthesia care included in the base
units.

(2) If the physician is not present with
the resident during pre- and post-
anesthesia care, then the physician may
bill the case as a medically directed case
in accordance with paragraph (d) of this
section.

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(Catalog of Federal Domestic Assistance
Program No. 93.774, Medicare—
Supplementary Medical Insurance Program)

Dated: October 28, 2003.

Thomas A Scully,

*Administrator, Centers for Medicare &
Medicaid Services.*

Approved: October 28, 2003.

Tommy G. Thompson,

Secretary.

Note: These addenda will not appear in the
Code of Federal Regulations.

**Addendum A—Explanation and Use of
Addenda B**

The addenda on the following pages
provide various data pertaining to the
Medicare fee schedule for physicians'
services furnished in 2003. Addendum B
contains the RVUs for work, non-facility
practice expense, facility practice expense,
and malpractice expense, and other
information for all services included in the
physician fee schedule.

In previous years, we have listed many
services in Addendum B that are not paid
under the physician fee schedule. To avoid
publishing as many pages of codes for these
services, we are not including clinical
laboratory codes and most alphanumeric
codes (Healthcare Common Procedure
Coding System (HCPCS) codes not included
in CPT) in Addendum B.

**Addendum B—2003 Relative Value
Units and Related Information Used in
Determining Medicare Payments for
2003**

This addendum contains the following
information for each CPT code and
alphanumeric HCPCS code, except for
alphanumeric codes beginning with B
(enteral and parenteral therapy), E (durable
medical equipment), K (temporary codes for
non-physicians' services or items), or L
(orthotics), and codes for anesthesiology.

1. *CPT/HCPCS code.* This is the CPT or
alphanumeric HCPCS number for the service.
Alphanumeric HCPCS codes are included at
the end of this addendum.

2. *Modifier.* A modifier is shown if there
is a technical component (modifier TC) and
a professional component (PC) (modifier
– 26) for the service. If there is a PC and a
TC for the service, Addendum B contains
three entries for the code: One for the global
values (both professional and technical); one
for modifier – 26 (PC); and one for modifier
TC. The global service is not designated by
a modifier, and physicians must bill using
the code without a modifier if the physician
furnishes both the PC and the TC of the
service.

Modifier – 53 is shown for a discontinued
procedure. There will be RVUs for the code
(CPT code 45378) with this modifier.

3. *Status indicator.* This indicator shows
whether the CPT/HCPCS code is in the
physician fee schedule and whether it is
separately payable if the service is covered.

A = Active code. These codes are
separately payable under the fee schedule if
covered. There will be RVUs for codes with
this status. The presence of an “A” indicator
does not mean that Medicare has made a
national decision regarding the coverage of