with sensory (FEEST), G0195 *Clinical evaluation of swallowing function (not involving interpretation of dynamic radiological studies or endoscopic study of swallowing),* and G0196 *Evaluation of swallowing involving swallowing of radio-opaque materials.*

Services formerly billed under G0193 will be billed using new CPT code 92612; services billed using G0194 will be billed using new CPT code 92614; services billed using G0195 will be billed using new CPT code 92610; and G0196 should be billed using new CPT code 92611.

G0197 *Evaluation of patient for prescription of speech generating devices,* G0198 *Patient adaptation and training for use of speech generating devices,* G0199 *Re-evaluation of patient using speech generating devices,* G0200 *Evaluation of patient for prescription of voice prosthetic,* and G0201 *Modification or training in use of voice prosthetic.*

Services formerly billed under G0197 will be billed using CPT code 92607 *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour,* and, if appropriate, CPT code 92608, *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient;* each additional 30 minutes; services billed using G0198 will be billed using CPT code 92609 *Therapeutic services for the use of speech-generating device, including programming and modification;* services billed using G0199 will be billed using CPT code 92607, using the -52 modifier if the service is less than 1 hour; services billed using G0200 will be billed using revised CPT code 92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech;* and services billed using G0201 will be billed using CPT code 92507.

G0240 *Critical Care Service delivered by a physician; face-to-face, during inter-facility transport of a critically ill or critically injured patient: first 30–74 minutes of active transport,* and G0241—*each additional 30 minutes (list separately in addition to G0240)*

Services formerly billed under G0240 and G0241 will be billed using CPT codes 99289 and 99290.

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 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. An updated all-inclusive list of codes was included in the November 1, 2001 physician fee schedule final rule in Addendum E and was subsequently corrected in a notice that was published in the **Federal Register** (66 FR 20681) on April 26, 2002.

The updated all-inclusive list of codes effective for January 1, 2003 is presented in Addendum E in this final rule. It is our intent to always use Addendum E of the annual physician fee schedule final rule for the physician self-referral update. The updated all-inclusive list of codes will also be available on our Web site at *http://cms.hhs.gov/medlearn/refphys.asp.*

B. Response to Comments

We received three comments regarding the code list. The comments and our responses are stated below.

Comment: One commenter agreed with the additions and deletions to the list of designated health services as published in the November 1, 2001 physician fee schedule final rule (66 FR 55312). The commenter expressed the understanding that we would address the comments regarding the original list of designated health services (published in the January 4, 2001 final rule) in a second final rule on the physician self-referral prohibition. A second commenter raised concerns about our decision (announced in the January 4, 2001 final rule) to exclude nuclear medicine from the definition of ''radiology and certain other imaging services.''

Response: The first commenter is correct in understanding that we intend to address substantive comments on the designated health services that are defined by reference to HCPCS and CPT codes in a second final rule concerning the physician self-referral prohibition. We will also address the second commenter's concerns regarding nuclear medicine in that final rule. As noted above, this update to the code list merely reflects changes to the most recent publications of HCPCS and CPT codes.

Comment: One commenter noted that we post on our Web site (*http://www.hcfa.gov/stats/cpt/rvudown.htm*) an Excel spreadsheet file containing all of the CPT/HCPCS codes with accompanying RVUs. The commenter suggested that we add a column indicating whether a code is considered a designated health service for purposes of the physician self-referral law, as well as in which category of designated health services it would be included. The commenter stated that, as changes are made, they would be scattered throughout several physician fee schedules.

Response: We believe that the commenter was concerned that updates to the list of designated health services under the physician self-referral law would be published in various fee schedules throughout the course of a year. This is not the case. We publish the annual update and the entire list of CPT/HCPCS codes in the physician fee schedule final rule. (Addendum E contains the updated all-inclusive list of codes.) We have no plans to publish an updated list of codes for physician self-referral purposes in any other fee schedule. We chose the physician fee schedule, as opposed to one of the other fee schedules, because we believe that physicians would be more likely to see it. We maintain a current list of codes used to define certain designated health services for purposes of the physician self-referral law on our Web site at *http://cms.hhs.gov/medlearn/refphys.asp.* We have decided not to make any changes to the RVU website at this time because we believe the updated all-inclusive list of codes used for purposes of physician self-referral is readily available to all physicians.

C. Revisions Effective for 2003

Table 9, below, identifies the additions and deletions to the comprehensive list of physician self-referral codes published in Addendum

E of the November 2001 physician fee schedule final rule and subsequently corrected in the April 26, 2002 correction notice (66 FR 20681). Table 9 also identifies the additions, deletions and revisions to the lists of codes used to identify the items and services that may qualify for the exceptions in § 411.355(g) (regarding EPO and other dialysis-related outpatient prescription drugs furnished in or by an end-stage renal dialysis (ESRD) facility) and in § 411.355(h) (regarding preventive screening tests, immunizations and vaccines).

We will consider comments with respect to the codes listed in Table 9 below, if we receive them by the date specified in the **DATES** section of this final rule.

TABLE 9.—ADDITIONS AND DELETIONS TO THE PHYSICIAN SELF-REFERRAL CODES

HCPCS	CPT [1]/Descriptor
Additions:	
51798	Us urine capacity measure
76070	Ct bone density, axial
76071	Ct bone density, peripheral
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
92601	Cochlear implt f/up exam < 7
92602	Reprogram cochlear implt < 7
92603	Cochlear implt f/up exam 7 >
92604	Reprogram cochlear implt 7 >
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
0010T	TB test, gamma interferon
0019T	Extracorp shock wave tx, ms
0020T	Extracorp shock wave tx, ft
0023T	Phenotype drug test, HIV 1
0026T	Measure remnant lipoproteins
0028T	Dexa body composition study
0029T	Magnetic tx for incontinence
0030T	Anitprothrombotin antibody
0041T	Detect UR infect agnt w/cpas
0042T	Ct perfusion w/contrast, cbf
0043T	Co expired gas analysis
G0256	Prostate brachy w palladium
G0261	Prostate brachytherapy w/rad
G0262	Sm intestinal image capsule
G0274	Radiopharm tx, non-Hodgkins
G0279	Excorp shock tx, elbow epi
G0280	Excorp shock tx other than
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0288	Recon, CTA for surg plan
J0636	Inj calcitriol per 0.1 mcg
J1756	Iron sucrose injection
J2501	Paricalcitol
J2916	Na ferric gluconate complex
Q3021	Ped hepatitis b vaccine inj
Q3022	Hepatitis b vaccine adult ds
Q3023	Injection hepatitis Bvaccine
Deletions:	
76830	Us, exam transvaginal
76872	Echo exam, transrectal
76873	Echograp trans r, pros study
86915	Bone marrow/stem cell prep
90744	Hepb vacc ped/adol 3 dose im
90746	Hep b vaccine, adult, im
90747	Hepb vacc, ill pat 4 dose im
92510	Rehab for ear implant
97014	Electric stimulation therapy
G0026	Fecal leukocyte examination
G0027	Semen analysis
G0050	Residual urine by ultrasound
G0131	CT scan, bone density study
G0132	CT scan, bone density study
G0193	Endoscopicstudyswallowfunctn

TABLE 9.—ADDITIONS AND DELETIONS TO THE PHYSICIAN SELF-REFERRAL CODES—Continued

HCPCS	CPT [1]/Descriptor
G0194	Sensorytestingendoscopicstud
G0195	Clinicalevalswallowingfunct
G0196	Evalofswallowingwithradioopa
G0197	Evalofptforprescipspeechdevi
G0198	Patientadapation&trainforspe
G0199	Reevaluationofpatientusespec
G0200	Evalofpatientprescipofvoicep
G0201	Modifortraininginusevoicepro
J0635	Calcitriol injection
J1755	Iron sucrose injection
J2915	NA Ferric Gluconate Complex
Revisions:	
76085	Computer mammogram add-on [when used in conjunction with 76092]

[1] CPT codes and descriptions only are copyrighted in the 2002 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

The ''Additions'' section of Table 9 generally reflects new CPT and HCPCS codes that become effective January 1, 2003. The one exception is the addition of the following emerging technology codes, referred to as Category III codes, which the AMA first included in the CPT effective January 1, 2002: 0010T, 0019T, 0020T, 0023T, and 0026T. CPT codes 0010T, 0023T, and 0026T represent clinical laboratory services while CPT codes 0019T and 0020T are therapy codes. These codes were addressed in the November 2001 physician fee schedule final rule with the clarification that coverage and payment of these services is generally at the discretion of the carrier. However, the portion of the November 2001 final rule that concerned the list of codes for physician self-referral purposes failed to address these new codes. Thus, we are adding the Category III codes that should have been included in last year's update. We also are adding the following new Category III codes issued for 2003 to which the physician self-referral prohibition applies: 0028T, 0029T, 0030T, 0041T, 0042T, and 0043T. CPT codes 0028T and 0042T are radiology services; CPT code 0029T is a physical therapy service; and, CPT codes 0030T, 0041T and 0043T are clinical laboratory services.

Table 9 also reflects the addition of 4 new codes (J0636, J1756, J2501 and J2916) to the list of dialysis-related outpatient prescription drugs that may qualify for the exception described in § 411.355(g) regarding those items. The physician self-referral prohibition will not apply to these drugs if they meet the conditions set forth in § 411.355(g). Table 9 also reflects the addition of 3 vaccine codes (Q3021, Q3022 and Q3023) to the list that identifies preventive screening tests, immunizations and vaccines that may qualify for the exception described in § 411.355(h) for such items and services. The physician self-referral prohibition will not apply to these vaccines if they meet the conditions set forth in § 411.355(h) concerning the exception for preventive screening tests, immunizations, and vaccines.

With the exception of CPT codes 76830, 76872 and 76873 for ultrasounds, the ''Deletions'' section of Table 9 reflects changes necessary to conform the code list to the most recent publications of CPT and HCPCS codes. We are deleting CPT code 76830 for transvaginal ultrasound and CPT codes 76872 and 76873 for transrectal ultrasounds because these codes should never have appeared on the list of designated health services. Our definition of ''radiology and certain other imaging services'' published in the January 2001 final rule (66 FR 956) specifically excludes any ultrasonic procedure that requires ''the insertion of a needle, catheter, tube, or probe''. Thus, although the deletion of these codes is not a change to conform to an annual change in CPT or HCPCS codes, we are making the change at this time so that the list of codes will accurately reflect the regulatory definition for ''radiology and certain other imaging services.''

Table 9 includes one revised CPT code. That is CPT code 76085, ''Computer mammogram add-on.'' In the CPT publication effective January 1, 2003, the CPT long descriptor was changed to delete the word ''screening'' so that the digitization no longer refers only to screening mammography. Because our exception under § 411.355(h) applies to preventive screening tests, we have revised the list of codes that may qualify for that exception to indicate that CPT code 76085 may qualify for the exception only when it is used in conjunction with CPT code 76092, ''Mammogram screening.''

VI. Physician Fee Schedule Update for Calendar Year 2003

A. Physician Fee Schedule Update

The physician fee schedule update is determined under a calculation methodology that is specified by statute. Under section 1848(d)(4) of the Act, the update is equal to the product of 1 plus the percentage increase in the Medicare Economic Index (MEI) (divided by 100) and 1 plus the update adjustment factor. For CY 2002, the MEI is equal to 3.0 percent (1.030). The update adjustment factor is equal to –7.0 percent (0.930). Section 1848(d)(4)(F) of the Act requires an additional –0.2 percent (0.998) reduction to the update for 2003. Thus, the product of the MEI (1.030), the update adjustment factor (0.930), and the statutory adjustment factor (0.998) equals the CY 2003 update of –4.4 percent (0.956).

The Department believes that the negative update is inappropriate because the current update system does not reflect actual, after the fact, data from earlier years. Instead, the Act requires the Department to rely upon estimates made in past years, even though the Department now has actual data for these particular years. Even though after-the-fact data show that for certain years actual increases differed to some degree from earlier estimates, the Department is unable to revise estimates without congressional action. We have exhaustively searched for a different interpretation of law that would allow us to revise estimates for earlier years administratively, but unfortunately, we had to conclude that current law does not permit such an interpretation.

Without congressional action to address the current legal framework, the Department is compelled to announce a