PROCEDURE CODES TO BE ADDED TO THE SITE-OF-SERVICE DIFFERENTIAL LIST—Continued

HCPCS	Description
11644	Removal of skin lesion.
12021	Closure of split wound.
13100	Repair of wound or lesion.
13101	Repair of wound or lesion.
13120	Repair of wound or lesion.
13121	Repair of wound or lesion.
13131	Repair of wound or lesion.
13132	Repair of wound or lesion.
13150	Repair of wound or lesion.
13151	Repair of wound or lesion.
13152	Repair of wound or lesion.
14000	Skin tissue rearrangement.
14020	Skin tissue rearrangement.
14040	Skin tissue rearrangement.
14041	Skin tissue rearrangement.
14060	Skin tissue rearrangement.
14061	Skin tissue rearrangement.
15740	Island pedicle flap graft.
19100	Biopsy of breast.
20670	Removal of support implant.
21025	Excision of bone, lower jaw.
21026	Excision of facial bone(s).
21040	Removal of jaw bone lesion.
21041	Removal of jaw bone lesion.
21208	Augmentation of facial bones.
21210	Face bone graft.
21215	Lower jaw bone graft.
21248	Reconstruction of jaw.
21249	Reconstruction of jaw.
21440	Repair dental ridge fracture.
21485	Reset dislocated jaw.
21550	Biopsy of neck/chest.
21920	Biopsy soft tissue of back.
23066	Biopsy shoulder tissues.
23330	Remove shoulder foreign body.
23620	Treat humerus fracture.
23931	Drainage of arm bursa.
24065	Biopsy arm/elbow soft tissue.
24362	Reconstruct elbow joint.
25065	Biopsy forearm soft tissues.
25624	Treat wrist bone fracture.
25635	Treat wrist bone fracture.
26070	Explore/treat hand joint.
26432	Repair finger tendon.
26605	Treat metacarpal fracture.
26645	Treat thumb fracture.
27086	Remove hip foreign body.
27323	Biopsy thigh soft tissues.
27520	Treat kneecap fracture.
27604	Drain lower leg bursa.
27613	Biopsy lower leg soft tissue.
27760	Treatment of ankle fracture.
27780	Treatment of fibula fracture.
27786	Treatment of ankle fracture.
27788	Treatment of ankle fracture.
28003	Treatment of foot infection.
28030	Removal of foot nerve.
28043	Excision of foot lesion.
28092	Removal of toe lesions.
28222	Release of foot tendons.
28261	Revision of foot tendon.
28313	Repair deformity of toe.
28400	Treatment of heel fracture.
28635	Treat toe dislocation.
28665	Treat toe dislocation.
29850	Knee arthroscopy/surgery.
30124	Removal of nose lesion.
30560	Release of nasal adhesions.
30580	Repair upper jaw fistula.

PROCEDURE CODES TO BE ADDED TO THE SITE-OF-SERVICE DIFFERENTIAL LIST—Continued

HCPCS	Description
30801	Cauterization inner nose.
31233	Nasal/sinus endoscopy, dx.
31235	Nasal/sinus endoscopy, dx.
31237	Nasal/sinus endoscopy, surg.
31238	Nasal/sinus endoscopy, surg.
31525	Diagnostic laryngoscopy.
31570	Laryngoscopy with injection.
33011	Repeat drainage of heart sac.
38300	Drainage lymph node lesion.
38505	Needle biopsy, lymph node(s).
40510	Partial excision of lip.
40801	Drainage of mouth lesion.
40814	Excise/repair mouth lesion.
40816	Excision of mouth lesion.
40819	Excise lip or cheek fold.
40820	Treatment of mouth lesion.
41000	Drainage of mouth lesion.
41008	Drainage of mouth lesion.
41105	Biopsy of tongue.
41110	Excision of tongue lesion.
41112	Excision of tongue lesion.
41113	Excision of tongue lesion.
41800	Drainage of gum lesion.
41805	Removal foreign body, gum.
41806	Removal foreign body, jaw-bone.
41827	Excision of gum lesion.
42000	Drainage mouth roof lesion.
42104	Excision lesion, mouth roof.
42106	Excision lesion, mouth roof.
42107	Excision lesion, mouth roof.
42160	Treatment mouth roof lesion.
42300	Drainage of salivary gland.
42310	Drainage of salivary gland.
42335	Removal of salivary stone.
42340	Removal of salivary stone.
42405	Biopsy of salivary gland.
42408	Excision of salivary cyst.
42700	Drainage of tonsil abscess.
45305	Proctosigmoidoscopy; biopsy.
45308	Proctosigmoidoscopy.
45309	Proctosigmoidoscopy.
46050	Incision of anal abscess.
46220	Removal of anal tab.
46610	Anoscopy; remove lesion.
46611	Anoscopy.
51710	Change of bladder tube.
51725	Simple cystometrogram.
51726	Complex cystometrogram.
51772	Urethra pressure profile.
51785	Anal/urinary muscle study.
52000	Cystoscopy.
52010	Cystoscopy & duct catheter.
52281	Cystoscopy and treatment.
52285	Cystoscopy and treatment.
53420	Reconstruct urethra, stage 1.
54065	Destruction, penis lesion(s).
55700	Biopsy of prostate.
56405	I & D of vulva/perineum.
56605	Biopsy of vulva/perineum.
57180	Treat vaginal bleeding.
57800	Dilation of cervical canal.
60000	Drain thyroid/tongue cyst.
61070	Brain canal shunt procedure.
63600	Remove spinal cord lesion.
64420	Injection for nerve block.
65270	Repair of eye wound.
65805	Drainage of eye.
66030	Injection treatment of eye.
66762	Revision of iris.

PROCEDURE CODES TO BE ADDED TO THE SITE-OF-SERVICE DIFFERENTIAL LIST—Continued

HCPCS	Description
67031	Laser surgery, eye strands.
67101	Repair, detached retina.
67105	Repair, detached retina.
67141	Treatment of retina.
67208	Treatment of retinal lesion.
67921	Repair eyelid defect.
69424	Remove ventilating tube.

E. Services of Teaching Physicians

1. General Background

The focus of this proposal is Medicare payment for those services furnished under graduate medical education (GME) programs that are not payable through the mechanisms established for direct GME costs by section 1886(h) of the Act. Section 1886(h) addresses Medicare payments to hospitals and hospital-based providers for the costs of approved GME programs in medicine, osteopathy, dentistry, and podiatry. These costs include residents' salaries and fringe benefits, physician compensation costs for GME program activities that are not payable on a fee schedule basis, and other GME program costs.

Medicare intermediary expenditures under section 1886(h) of the Act for fiscal year (FY) 1996 are estimated to be approximately $1.9 billion. In addition, under section 1886(d)(5)(B) of the Act, Medicare makes additional payments to teaching hospitals under the prospective payment system (PPS) for the higher indirect operating costs hospitals incur by having GME programs. (These are costs other than direct GME costs.) Medicare indirect GME payments for FY 1996 are estimated to be approximately $4.9 billion. Medicare also supports GME programs in teaching hospitals through billings for the services of attending physicians who involve residents in the care of their patients. The amount of Medicare expenditures for these services is not known since attending physicians are not required to distinguish between services they personally furnish and those they furnish as attending physicians in claims submitted to the part B carriers.

This proposal addresses services of teaching physicians that are payable on a fee schedule basis, services of residents in settings that are not payable under section 1886(h), and services of moonlighting residents. In addition, the proposed rule addresses, but does not substantially change, existing rules on related issues on Medicare payments for the services of residents in approved