breast disease is no longer present, screening mammography might be appropriate.

We also propose that certain minor and technical changes be made in the limitations on coverage of screening mammography services to make them consistent with the proposed revisions to the definitions in ''diagnostic'' and ''screening'' mammography in § 410.34(a)(1) and (a)(2), respectively, and to simplify the language in § 410.34(d)(1) regarding the postmastectomy patient.

J. Use of Category-Specific Volume and Intensity (VI) Growth Allowances in Calculating the Default Medicare Volume Performance Standard (MVPS)

Currently, the default formula uses an estimate of the average annual percentage growth in the VI of physician services that is the same for all categories of physician services. Although historically the data available to us allowed an accurate estimate of the overall growth in the VI of physician services, they did not allow us to estimate the VI growth for each individual category of service with the degree of accuracy required for the MVPS calculation. More recent data now allow us to do this. We propose to calculate the MVPS for FY 1996 and all future years based on estimates of the average VI growth specific to each category. This would be consistent with our use of category-specific estimates of the MVPS factors for the weighted-average increase in physician fees and the percentage change in expenditures resulting from changes in law or regulations. The effect this proposal would have on a future MVPS for a category depends on the difference between the VI growth for that category and for physician services overall. To illustrate, the following table compares the estimated FY 1996 VI allowance for each category based on the overall average and the category-specific average:

	Overall average VI (percent)	Category-specific VI (percent)
Surgical Services	4.4	2.3
Primary Care Services	4.4	5.3
Nonsurgical Services	4.4	5.1
All Physician Services	4.4	4.4

As can be seen from the table, the FY 1996 MVPS VI allowance for primary care is higher using the category-specific VI factor than using the single VI factor. This is because the average VI growth for primary care services has been higher than the average VI growth for all physician services. Although for FY 1996 this change in methodology would result in a higher primary care MVPS, this does not necessarily mean it would have a similar result in future years. The impact on any individual category is dependent on the future relationship between the average VI growth for that category and for physician services overall. If future growth in the VI of primary care services is lower than overall physician growth, this change would result in a lower MVPS for primary care services. Similar reasoning applies to the surgical and other nonsurgical categories. This proposal reflects a policy change that is not explicitly addressed in our regulations.

Although we are proposing this regulatory change now to address immediate problems in the fee schedule, it is our intention to move toward the development of a legislative proposal to implement a single MVPS and CF for all Medicare physician fee schedule services. Because of past differential updates, the surgical CF is currently 8 percent and 14 percent higher than the CFs for primary care and other nonsurgical services, respectively. We are concerned that this situation clearly undermines the original intent of the Medicare physician fee schedule.

III. Issue for Change in Calendar Year (CY) 1998—Two Anesthesia Providers Involved in One Procedure

The certified registered nurse anesthetist (CRNA) fee schedule regulations provide that if an anesthesiologist and a CRNA are both involved in a single procedure, we deem the service to be personally performed by the anesthesiologist and allow payment only for the physician service.

Approximately equal percentages of CRNAs are employed by physicians and hospitals. When the physician employs the CRNA, payment for both the CRNA's and the physician's service go into the same practice revenue pool that is used to pay both providers. Our policy described above does not create any problems for this type of arrangement, since the practice views itself as being paid for the service. However, if the hospital employs the CRNA and the physician is involved with this CRNA in a single procedure, then only the physician is paid. The hospital is not paid under the Medicare program for the CRNA service.

Although we have not received many complaints from hospitals about this policy, the CRNAs have stated that our policy causes hospitals to lower CRNA salaries. While the CRNAs have not been able to produce information on the extent of this practice, they believe that this type of arrangement is not unusual.

The CRNAs also have expressed concern that the CRNA is the person furnishing the service to the patient. The anesthesiologist is present in the room usually because the hospital has an operating policy that the CRNA service always be supervised or directed.

Currently our medical direction rules apply only to concurrent procedures (that is, two, three or four) directed by a physician. We have not applied these rules to a single procedure. The application of the medical direction payment policy to a single procedure would have resulted in increased program payment, approximately 30 percent greater than the current policy. Thus, part of our concern for not extending the medical direction payment policy to a single procedure has been the additional cost to the Medicare program.

Section 13516 of OBRA '93 established a new payment methodology for both the physician's medical direction service and the medically directed CRNA service. For 1994, the allowance for each of these services is equal to 60 percent of the allowance that would be recognized for the procedure personally performed by the physician alone. These percentages are reduced each year so that in 1998, the allowance for each service is equal to 50 percent of the allowance that would be recognized for the procedure personally performed by the physician alone. The objective is that in 1998, the allowance for anesthesia care in a given area will be the same whether the care is furnished by the physician alone, a nonmedically directed CRNA, or the anesthesia care team.

As a result of the revised payment methodology for the anesthesia care team, we propose to apply the medical direction payment policy to the single procedure involving both the physician and the CRNA. Thus, in § 414.46 we propose to revise paragraphs (c) and (d) to state that in this situation the allowance for the medical direction 50 service of the physician and the medically directed service of the CRNA or the anesthesiologist assistant is based on the specified percentage of the allowance in § 416.40(d)(2). In addition, we propose that in 1998 and later years, this allowance is equal to 50 percent of the allowance for personally performed procedures.

We propose to implement this policy on January 1, 1998. At that time, the change in policy will be done in a budget-neutral manner. If we were to