the ER physician from billing for the same service.

*E. Extension of Site-of-Service Payment Differential to Services in Ambulatory Surgical Centers (ASCs)*

We propose to extend the site-of-service payment differential to office-based services if those services are furnished in an ASC, effective for services furnished beginning January 1, 1996. We propose adding 152 codes to the list. Were it not for budget-neutrality adjustments, we estimate that these additions would result in a $25.7 million reduction in Medicare payments.

*F. Services of Teaching Physicians*

This proposed change would remove the single attending physician criteria for hospital patients and allow and promote supervision of the care by physician group practices. We believe allowing for more than one teaching physician per beneficiary inpatient stay would result in negligible additional cost, but the lack of any data prevents us from quantifying the effects of this change. In addition, this proposed rule would incorporate long-standing Medicare coverage and payment policy regarding the circumstances under which the services of residents are payable as physician services.

We propose to require the physical presence of a teaching physician during the key portion of the service. Details regarding the physical presence of a teaching physician during different types of services and procedures are discussed in section II. F. of this preamble. Although we lack specific data, we believe that the provisions of this part of the proposed rule would have little budgetary effect.

*G. Unspecified Physical and Occupational Therapy Services (HCPCS Codes M0005 through M0008 and H5300)*

We propose to eliminate HCPCS codes M0005 through M0008 and H5300 and redistribute the RVUs to codes in the physical medicine and rehabilitation section of the CPT (codes 97010 through 97039). The codes we propose to delete are general codes that do not describe adequately the service being provided. Their use precludes effective review necessary to ensure that the services being paid are covered by Medicare. In 1995, the AMA revised the CPT codes in the Physical Medicine and Rehabilitation section of the CPT to better reflect the provision of physical and occupational therapy services.

We believe that each unit of service currently billed under the codes we propose to delete would be billed under a CPT or HCPCS code and that the total amount of Medicare payment for physical medicine services would not change significantly as a result of the elimination of these codes. Therefore, we are assuming that there would not be any additional costs or savings as a result of this proposed change in billing. Since the original codes were not descriptive, we would have no way of comparing payments. However, we believe we would eliminate any manipulation of payment and improve the data we collect by requiring these practitioners to use the more specific codes when billing for services.

*H. Transportation in Connection With Furnishing Diagnostic Tests*

Except for portable x-ray and EKG equipment, this proposed rule would no longer authorize payments for the transportation of diagnostic equipment to the patient or to a site, such as a physician office, for use in furnishing tests to Medicare beneficiaries. The transportation expense is ''bundled'' into the payment for the procedure. Individual carrier policies on making transportation payments vary. This proposed rule would establish a national Medicare policy on payments for the transportation of diagnostic test equipment. The little data we have indicate that the transportation payment is often several times higher than the payment we make for the specific procedure furnished.

*I. Maxillofacial Prosthetic Services*

We propose to establish national RVUs for these services and to discontinue pricing by individual carriers. We estimate that total estimated expenditures for CPT codes 21079 through 21087 and codes G0020 and G0021 based on the proposed RVUs will be approximately $2.4 million in CY 1996. The 1994 Medicare expenditures for the codes under the carrier pricing methodology were approximately $1.5 million which, if updated for 1995 would be approximately $1.6 million. Thus, we estimate an increase of approximately $800,000 for these codes. However, total expenditures for physician services would not increase as a result of this proposal because we would implement this change in a budget neutral manner in accordance with section 1848(c)(2)(B)(II) of the Act.

These services are furnished most frequently by oral surgeons (dentists only) and by maxillofacial surgeons. Because the total expenditures for these services are estimated to increase slightly, we expect that in general the physicians who perform and bill for these procedures will realize an increase in payment. However, in some areas, the payment amounts based on national RVUs may be lower than those calculated by the local carrier.

*J. Coverage of Mammography Services*

We propose to expand the definition of ''diagnostic'' mammography to include as candidates for this service asymptomatic men or women who have had a personal history of biopsy-proven breast disease. At present, the definition includes as candidates for mammography services only persons showing signs or symptoms of breast disease. We do not believe this change will result in a significant increase in the total number of mammography services because information from carriers indicates that most asymptomatic patients with a personal history of breast disease are already receiving diagnostic mammography services.

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

The use of category-specific VI in the MVPS default formula would be budget neutral overall, although it would have redistributional effects on the surgical, primary care, and nonsurgical categories.

*L. Two Anesthesia Providers Involved in One Procedure*

We propose to apply the medical direction payment policy to the single procedure involving both the physician and the CRNA. We do not propose to implement this policy until January 1, 1998 at which time the proposal will be budget neutral. In 1998, the allowance for the medically-directed CRNA service and the medical-direction service of the anesthesiologist will be equivalent to 50 percent of the allowance recognized for the service personally performed by the anesthesiologist alone. Thus, payment for both services will be no different than what would be allowed for the anesthesia service personally performed by the anesthesiologist.

Although this proposal is budget neutral, total payments to anesthesiologists will decrease slightly and payments to the CRNAs' employers will increase slightly. We cannot quantify the amount of the losses to the anesthesiologists or the gains to the CRNAs' employers. However, anesthesiologists can lessen their losses by actually personally performing as many of these cases as possible and receiving the same allowance they