issue of psychiatric services delivered in a managed care setting, will be addressed as part of the 5-year review process.

Final Decision: We will bundle the payment for CPT codes 90825 and 90887 into the payment for other psychiatric services. Therefore, separate payment for CPT codes 90825 and 90887 is not allowed.

This policy change is not explicitly addressed in our regulations.

3. Fitting of Spectacles

We proposed to cease paying separately for the fitting of glasses and low vision systems. The payment for the fitting of spectacles is included in the payment for the spectacles in the same way that payment for other prosthetic fitting services is included in the payment for the prosthetic device.

We proposed to assign a ''B'' status indicator to CPT codes 92352, 92353, 92354, 92355, 92358, and 92371 to indicate that the services are covered under Medicare but that payment for them is bundled into the payment for the spectacles. We proposed to implement this in a budget-neutral manner by redistributing the current RVUs for these services across all RVUs.

This reflects a policy change that is not explicitly addressed in our regulations.

Comment: A commenter believed that these fitting services should continue to be paid separately because of the time and expertise required to fit glasses for aphakic patients and low vision aids.

Response: The fitting of spectacles is covered under section 1861(s)(8) of the Act. Services under this section are not included in the definition of physician services as defined in section 1848(j)(3) of the Act and are not payable under the physician fee schedule. Although we have been allowing payment, the fitting of spectacles is included in the payment for the spectacles in the same way that payment for other prosthetic fitting services are included in the payment for the device. Under the current system, duplicate payment has been made for the aforementioned procedure codes.

Final Decision: We will no longer pay separately for CPT codes 92352, 92353, 92354, 92355, 92358, and 92371. Beginning January 1, 1996, these codes will be assigned a ''B'' status indicator to indicate that the services are covered under Medicare, but payment for them is bundled into the payment for the spectacles.

This policy change is not explicitly addressed in our regulations.

C. X-Rays and Electrocardiograms Taken in the Emergency Room

We proposed to pay for the x-ray and/or electrocardiogram (EKG) interpretation that contributes to the diagnosis or treatment of the patient in the emergency room. We will pay for only one x-ray and/or EKG interpretation except under unusual circumstances.

Comment: The comments from radiologists opposed every aspect of the proposal. The primary point raised by virtually all of these commenters was that, by training and experience, they were more qualified than emergency physicians or other nonradiologists to furnish these interpretations. Some radiologists commented that we should require board certification as a requirement to bill for the interpretation of x-rays.

Response: In paying for physicians' services under the Act, we are charged with determining the following:

- Is the service covered under Medicare?
- Is the service reasonable and necessary for the individual beneficiary?
- Is the physician licensed to perform the service in the State in which it is furnished?

In the case of a licensed physician who has furnished a covered service (that is not payable through another code) to a Medicare beneficiary in an emergency room, it is not readily apparent to us upon what basis the claim can be denied. There is no portion of the Act upon which to base a decision that only board-certified radiologists can furnish x-ray interpretations or board-certified cardiologists can furnish EKG interpretations. (Where the Congress has determined that there should be special qualifications in order to furnish a service, as in the case of mammography, a provision was made in the statute.) Our proposed policy for x-ray and EKG interpretation is consistent with how we generally treat other physician services.

Comment: Emergency room physicians supported the direction of the proposal but requested clarification of the proposal including its effect on payments for second interpretations. Many commended us for proposing to change the existing policy but criticized the agency for not going far enough. Several emergency physicians commented that it was unethical for us to withhold compensation from physicians who make life-saving decisions every day based on x-ray and EKG interpretations.

Response: Our proposal addressed situations in which both the emergency physician and the radiologist/cardiologist billed for the same interpretation. It is that situation in which a determination needs to be made of which interpretation contributed to the diagnosis and treatment of the individual patient. If an emergency physician does not bill for the interpretation, there would be no change from existing policy. We would like to stress that if the only bill received is from the radiologist or cardiologist, it is paid on the same basis as current claims.

Comment: We received relatively few comments from physicians and other entities specializing in cardiology procedures. Their comments focused on the cardiologists' greater qualifications to interpret EKGs based on their training and experience.

Response: The discussion above about the qualifications of the interpreting radiologist would also apply here. The situation with EKGs is somewhat different than with x-rays because section 13514 of OBRA 1993, Public Law 103–66, enacted August 10, 1993, requires us to make separate payment for EKG interpretations and to exclude the RVUs for EKG interpretations from the RVUs for visits and consultations, making the EKG portion of the current policy as set forth in section 2020G of the Medicare Carriers Manual obsolete.

Comment: We proposed that the radiologist or cardiologist should be paid for the interpretation when it is performed contemporaneously with the diagnosis and treatment of the emergency room patient. This standard would be met if an interpretation were initially conveyed to the treating physician verbally. Nearly all commenters seemed to be troubled by the use of the term ''contemporaneous'' and requested clarification of the term. Some radiologists indicated that their interpretation is furnished contemporaneously if it is provided timely, which commenters variously defined as 12–24 hours. Other radiologists indicated that there are teleradiology hook-ups to radiologists, homes which should satisfy the need for contemporaneous interpretations. Several emergency room specialists indicated that the circumstances under which a radiologist or cardiologist furnishes a contemporaneous interpretation as discussed in the proposal should be clarified. They expressed concern that the provision of a verbal interpretation by the specialist to the emergency room physician could be used to circumvent the stated intention to pay for the interpretation used in the diagnosis and treatment of the beneficiary.