inclusion in the beneficiary's medical record maintained by the hospital. We have placed this requirement in the radiology section of the regulations on services of physicians in providers at § 405.554(a). (Under the recodification, this section becomes 415.120(a)).

• We distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure. An interpretation and report of the procedure is separately payable by the carrier. A review of the findings of these procedures, without a written report, does not meet the conditions for separate payment of the service since the review is already included in the emergency room visit payment.

• In the case of multiple bills for the same interpretation and report, we will instruct the carriers to adopt the following procedures:

+ Cease consideration of physician specialty in deciding which interpretation and report to pay regardless of when the service is performed.

+ Pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient.

+ Pay for the interpretation billed by the cardiologist or radiologist if the interpretation of the procedure is performed at the same time as the diagnosis and treatment of the beneficiary. (This interpretation may be a verbal report conveyed to the treating physician that will be written in a report at a later time.)

• We will minimize the carrier's need to make decisions about which claim to pay when multiple claims for the interpretation and report of the same procedure are received by—

+ Encouraging hospitals to work with their medical staffs to ensure that only one claim per interpretation is submitted;

+ Advising hospitals that if they allow a physician to perform and bill for a medically necessary service (the interpretation and report) in an emergency room and permit another physician to perform and bill for the same service, the Medicare carrier will not pay two claims;

+ Advising hospitals that the Medicare carrier may determine that the hospital's "official interpretation" is for quality control and liability purposes only and is a service to the hospital rather than to an individual beneficiary; and

+ Advising hospitals that Medicare fiscal intermediaries consider costs incurred for quality control activities in determining payments to hospitals. • When the Medicare carrier receives only one claim for an interpretation and the procedure is reasonable and necessary, the carrier will pay the claim. We will presume that the one service billed was a service to the individual beneficiary and not a quality control measure.

Manual instructions to the carriers will be issued as soon as possible.

This policy change is not explicitly addressed in our regulations.

## D. Extension of Site-of-Service Payment Differential to Services in Ambulatory Surgical Centers

We proposed extending the site-ofservice payment differential to services on the ambulatory surgical center (ASC) covered list of procedures that are predominantly performed in an office setting. We see no reason for exempting these procedures from the site-of-service payment differential. The practice expense RVUs duplicate many of the overhead expenses included in the ASC facility and hospital payment rates. As such, when a service is provided in an ASC or a hospital, the physician does not bear the same level of practice costs as when the same service is furnished in the office. Therefore, in §414.32 ("Determining payments for certain physician services furnished in facility settings"), we proposed to modify in paragraph (d) ("Services excluded from the reduction") the subordinate paragraph (d)(2), which would have the effect of applying the site-of-service payment differential to ASC services. The payment differential does not apply to procedures performed in an ASC that are not on the ASC list because no facility payment is made.

*Comment:* Many commenters stated that the Act provides that procedures included on the ASC list, by definition, are not office-based procedures. Commenters indicated that we had concluded in previously published regulations on ASCs that certain procedures, such as cystoscopies, prostate biopsies, and skin lesion excisions, are not office-based procedures.

*Response:* Historically, the ASC list included only procedures that were performed less than half of the time in an office setting. Consequently, the ASC list and the site-of-service payment differential lists were mutually exclusive. Over time, many procedures shifted from being performed predominately in ASCs to being performed predominately in offices. However, in many cases the procedures were retained on the ASC list because we were persuaded by arguments that while the procedure may usually be done in an office, there were circumstances justifying using an ASC. Therefore, the two lists are no longer mutually exclusive. Retention of certain procedures on the ASC list does not imply that they cannot appropriately be performed in an office. In fact, the only procedures proposed for addition to the site-of-service differential payment list are those that are performed in an office setting the majority of the time.

*Comment:* Several commenters questioned the accuracy of data or indicated that they could not fully evaluate the proposals because we did not publish data on which the site-ofservice list is based. Some stated we should use clinically-based criteria instead of purely objective, arithmetic data.

Many commenters indicated that many of the procedures added to the site-of-service differential list were inappropriate and unlikely to be officebased procedures because they are extraordinarily complicated procedures, require anesthesia or sophisticated equipment, or need to be evaluated on a case by case basis. Several commenters believed the list to be arbitrary and unfair. Others indicated that physicians should not be punished for selecting the medically appropriate site for certain procedures on the list. One commenter agreed that we should encourage physicians to perform procedures in an office when it is safe and effective.

Another commenter stated that we should pay urologists for supplies and a small facility fee to shift procedures to the less costly office setting.

Some commenters stated that because nasal/sinus endoscopy codes were added to the ASC list effective January 1, 1994 the site-of-service data are likely to be skewed toward the physician's office setting. Other commenters stated the CPT description for breast biopsy (CPT code 19100) was recently changed to include only core needle aspiration while fine needle aspiration is now reported using code CPT code 88170. One commenter agreed that breast biopsy should be on the list. Other commenters argued that the data do not distinguish between techniques employed. Many commenters indicated that the policy does not account for gender differences. For example, cystoscopies performed on males are more difficult and painful and are inappropriate for an office setting.

*Response:* According to our data, the procedures on the site-of-service payment differential list are performed in a physician's office more than 50 percent of the time. Inclusion of procedures on the list is not intended to