Because the CPT codes were introduced in 1991 and the HCPCS codes in 1995, we have little or no charge data on which to base practice expense and malpractice expense RVUs in accordance with section 1848(c)(2)(C) of the Act. Therefore, we imputed the practice expense and malpractice expense RVUs from the work RVUs based on the practice cost shares provided by the American Association of Oral and Maxillofacial Surgeons. Those shares are 54.7 percent for practice expense and 4.4 percent for malpractice expense.

Comment: We received numerous comments in response to the RVUs assigned to maxillofacial prosthetic services. Although there was some support for eliminating the carrier-priced status of these services and at least one commenter expressed appreciation of the work RVUs, the commenters were unanimous in objecting to our use of the American Association of Oral and Maxillofacial Surgeons' practice cost shares. These commenters stated that the practice and malpractice expenses for the sub-specialty of maxillofacial prosthetics differ substantially from those of maxillofacial surgery, primarily due to increased laboratory, supply, and maxillofacial material costs. The commenters believed that the RVUs imputed for practice expense are too low and should be between 65 and 70 percent to accurately reflect the practice expenses incurred by the prosthodontist. According to the commenters, the RVUs we proposed for malpractice expense are too high and should be in the range of 1 percent to 3.5 percent of the total RVUs.

Because maxillofacial prosthodontic practice expenses include laboratory charges (including precious metals and impression materials) that are rarely seen in oral and maxillofacial surgery and include significantly higher practice expenses, the commenters requested that we revise the RVUs for maxillofacial prosthetic procedures to account for the higher practice cost shares.

Response: In the absence of charge data, we use the best available data to impute practice expense and malpractice expense RVUs. Maxillofacial surgery represented the specialty for which we had available data that used comparable survey methods. We note, also, that we are currently working on a resource-based practice expense study and, as part of this effort, hope to have more definitive data in the future. At that time, we will reevaluate all maxillofacial practice expense RVUs.

Final Decision: We are recommending no additional modifications to the RVUs for maxillofacial codes at this time. The proposed RVUs for CPT codes 21079 through 21087 are accepted as final. HCPCS code G0020 has been replaced by new CPT code 21076, and G0021 has been replaced by new CPT code 21077. Because these new CPT codes describe the same services as the HCPCS codes, the assigned RVUs will not change. Therefore, the proposed relative values for G0020 and G0021 are accepted as final but are assigned to CPT codes 21076 and 21077, respectively. G0020 and G0021 are deleted effective January 1, 1996. All RVUs for oral maxillofacial prosthetic services are published in Addendum B.

I. Coverage of Mammography Services

Based on recommendations from the Food and Drug Administration, the National Cancer Institute, and a carrier medical directors' workgroup, we proposed to revise the definitions of ''diagnostic'' and ''screening'' mammography in § 410.34 to make them consistent with previous Medicare coverage policy regarding ''diagnostic'' mammography and with the way these terms are used in general clinical practice in the United States. Specifically, we proposed to expand the definition of ''diagnostic'' mammography in § 410.34(a)(1) to include as candidates for this service asymptomatic men or women who have a personal history of biopsy-proven breast disease. However, we proposed to retain the substance of the present definition of ''screening'' mammography in § 410.34(a)(2) so that patients with a personal history of breast disease can be considered candidates for the ''screening'' examination, if the woman's attending physician determines that this is appropriate.

Comment: One commenter indicated that, because of the overlap in the definitions for ''screening'' and ''diagnostic'' mammograms, the proposal would lead to allowing almost every mammogram furnished to a Medicare beneficiary to be covered as a diagnostic mammogram, thereby increasing Medicare costs for mammograms.

Response: We do not believe the revised definitions will significantly increase the total number of diagnostic mammography services furnished. Information from the Medicare carriers indicates that most asymptomatic patients with a personal history of biopsy-proven breast disease are already receiving diagnostic mammograms rather than screening mammograms. This final rule is consistent with general clinical practice in the United States and falls within the parameters of Medicare statutory coverage for diagnostic and screening mammograms.

Comment: Two commenters recommended that we clarify the term ''a personal history of biopsy-proven breast disease.'' One commenter assumed that both benign (for example, fibroadenomas) and malignant neoplasms would fall in that category. The other commenter suggested that we make a distinction between ''a personal history of breast cancer'' and ''a personal history of biopsy-proven breast disease.''

Response: We agree that this point needs to be clarified. The intent of the proposal was to include both benign and malignant neoplasms within the meaning of the term ''a personal history of biopsy-proven breast disease.'' Breast diseases, including both benign and malignant neoplasms, that require a biopsy and subsequently demonstrate a pathologic process, establish a history of biopsy-proven breast disease. In the final rule, we are clarifying this by revising the term ''a personal history of biopsy-proven breast disease'' to read ''a personal history of breast cancer or a personal history of biopsy-proven benign breast disease.''

Comment: One commenter expressed the opinion that the term ''fibrocystic disease'' referred to in the preamble of the proposed rule should be more appropriately referenced as ''fibrocystic changes.''

Response: The terms ''fibrocystic disease'' and ''fibrocystic changes'' are often used synonymously. We agree that, in our discussion of this subject in the preamble to the proposed rule, the preferred term is ''fibrocystic changes.''

Comment: One commenter suggested that the proposal should be revised to include, as candidates for diagnostic mammography, women who have a family history of breast disease (within one generation).

Response: While there is a growing consensus among clinicians and mammography experts that family history is an important etiologic factor that places women at high risk of developing breast cancer, and thus eligible for screening mammography at frequent intervals, the data are not sufficiently definitive at present to consider these women to be candidates for diagnostic mammography.

Comment: One commenter suggested that we discuss whether women who have tested positive for any of the recently identified breast cancer genes, such as BRCA1, should be considered to have a personal history of breast cancer