within the meaning of this term in the regulations.

*Response:* As we stated in the final rule concerning Medicare coverage of screening mammography that was published in the Federal Register on September 30, 1994 (59 FR 49826), the term ''a personal history of breast cancer'' in § 410.34(b)(4) of the regulations was intended to mean that there is documented evidence in the woman's medical record that she has tested positive for breast cancer. While the development of screening tests in this area is promising, we do not believe that the inclusion of these tests as specific criteria for coverage of screening mammograms is warranted at this time. However, as new information becomes available, we will reconsider this issue.

*Final Decision:* We are adopting our proposal to revise the definitions of the terms diagnostic and screening mammography in § 410.34. As requested by several commenters, we are clarifying the final regulations text 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.''

III. Anesthesia Issues

*A. Modifier Units for Anesthesia Services*

In the January 26, 1989 proposed rule (54 FR 3794) and the August 7, 1990 final rule implementing the uniform relative value guide for physician anesthesia services, we stated our national policy that Medicare carriers cannot recognize payments for anesthesia modifiers. Anesthesia modifiers represent additional units charged by physicians because of the patient's advanced age, poor physical health status, or unusual circumstances including the performance of anesthesia under emergency circumstances or anesthesia complicated by the use of controlled hypotension.

For the 3 years preceding the physician fee schedule, Medicare carriers had uniformly implemented the policy of not allowing modifier units in determining payment for physician anesthesia services.

The physician fee schedule legislation required us to use the uniform relative value guide to the extent feasible and to make any necessary adjustments to the anesthesia CF. In the November 1991 final rule (56 FR 59509) to implement the physician fee schedule, we stated that we were continuing to use the uniform relative value guide to determine payment for physician anesthesia services under the physician fee schedule. Since it was the established uniform practice for Medicare carriers not to recognize modifier units, we believed it was sufficient to write the regulations to explain only those elements that the Medicare carrier would recognize in calculating anesthesia payments, namely anesthesia base and time units. Thus, in the final rule to implement the physician fee schedule, we did not include specific regulatory language prohibiting anesthesia modifier units.

Some administrative law judges have interpreted the absence of language expressly prohibiting the use of modifier units under the physician fee schedule to mean that modifier units can be allowed. This is clearly an incorrect interpretation of our regulations, and we have chosen to clarify this matter by including a specific reference in the regulations stating that modifier units are not allowed. We have revised § 414.46 to reflect this policy. Because this clarification of the regulations is an interpretive change, the law does not require prior notice and comment. However, we will accept comments on this change in the regulations.

*B. Issue for Change in Calendar Year 1998—Two Anesthesia Providers Involved in One Procedure*

As a result of the revised payment methodology for the anesthesia care team established by section 13516 of OBRA 1993, we proposed to apply the medical direction payment policy to the single procedure involving both the physician and the certified registered nurse anesthetist. Thus, in § 414.46 we proposed to revise paragraphs (c) and (d) to state that, in this situation, the payment allowance for the medical direction service of the physician and the medically directed service of the certified registered nurse anesthetist or the anesthesiologist assistant is based on the specified percentage of the payment allowance in § 414.46(d)(3). In addition, we proposed that in 1998 and later years, this payment allowance is equal to 50 percent of the allowance for personally performed procedures.

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

*Comment:* Commenters referred to those complicated anesthesia cases when it may be medically necessary for two anesthesia care providers to be involved. The anesthesia providers could be an anesthesiologist and a certified registered nurse anesthetist or two anesthesiologists. They asked whether we would permit full payment for each of these providers or subject these providers to the new proposal in which case each provider would receive only 50 percent of the allowance recognized for the anesthesia case personally performed by a single anesthesiologist.

*Response:* We are not changing the current policy under which the Medicare carriers can, on the basis of medical necessity, recognize full payment for the services of each of two anesthesia providers if both providers are needed in a single anesthesia case. Thus, the Medicare carriers can continue, based on medical necessity, to allow full payment for the service furnished by each anesthesia provider in a single case.

*Comment:* A commenter offered an alternative proposal that would achieve budget neutrality but allow implementation beginning in 1996. Under the commenter's proposal, which would take effect in 1996, the payment allowance for both the certified registered nurse anesthetist and the anesthesiologist involved in the single case would be 50 percent of the allowance recognized for the single anesthesiologist.

*Response:* The law recognizes that an anesthesia service is either personally performed by a physician (or nonmedically directed certified registered nurse anesthetist) or the case is medically directed. We have implemented the medical direction policy as applying only to two, three, or four concurrent procedures. Therefore, we deemed the case involving both the anesthesiologist and the certified registered nurse anesthetist to be personally performed by the physician. In the July 26, 1995 proposed rule, we proposed to modify the definition of medical direction to include a single procedure in addition to concurrent procedures. The statutory provisions governing medical direction provide that, in 1996, the payment allowance for both the certified registered nurse anesthetist and the physician are equal to 55 percent of the single anesthesiologist payment allowance. Thus, there is no direct authority in the law to recognize a payment allowance that is 50 percent of the single anesthesiologist payment allowance for both the certified registered nurse anesthetist and the physician.

*Final Decision:* We will apply the medical direction payment policy to the single procedure involving both the physician and the certified registered nurse anesthetist. We will implement this policy on January 1, 1998. At that