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 final rule have no budgetary effect because we believe that the potential costs are offset by the potential savings.

G. Unspecified Physical and Occupational Therapy Services (HCFA Common Procedure Coding System Codes M0005 Through M0008 and H5300)

We are eliminating HCPCS codes M0005 through M0008 and H5300 and redistributing the RVUs to codes in the physical medicine and rehabilitation section of the CPT (codes 97010 through 97799). The codes we are deleting are general codes that do not describe adequately the service being furnished. Their use precludes effective review necessary to ensure that the services being paid are covered by Medicare. In 1995, the American Medical Association 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 are deleting will be billed under a CPT or HCPCS code and that the total amount of Medicare payment for physical medicine services will not change significantly as a result of the elimination of these codes. Therefore, we believe there will be no additional costs or savings as a result of this change in billing. Since the original codes were not descriptive, we had no way of comparing payments. However, we believe that we are eliminating potential manipulation of payment and are improving the data collected by requiring practitioners to use the more specific codes when billing for these services.

H. Transportation in Connection With Furnishing Diagnostic Tests

Under the policy adopted in this final rule, we are restricting the discretion of carriers to make separate payments for the transportation of diagnostic testing equipment. Effective for services furnished beginning January 1, 1996, the general policy is that separate transportation payments will be made only in connection with the following services:

- X-ray and standard EKG services furnished by an approved portable x-ray supplier; and
- Standard EKG services furnished by an independent physiological laboratory under special conditions.

For all other types of diagnostic tests payable under the physician fee schedule, travel expenses are considered to be ''bundled'' into the payment for the procedure, and Medicare carriers will pay for the transportation of equipment only on a ''by report'' basis under CPT code 99082 if a physician submits documentation to justify the ''very unusual'' travel as set forth in section 15026 of the Medicare Carriers' Manual.

We are unable to assess the impact of this new national policy because carriers have had such varying payment policies on this issue. We had thought that this might be a significant policy change since we had received many inquiries on the subject in recent years; however, we received fewer than 10 comments on this policy as set forth in the proposed rule, and we now conclude that the national impact of the new policy will not be significant. There will likely be an impact on payments to independent physiological laboratories in some areas in which transportation payments were made before January 1, but it is not possible to assess these reductions from the comments received.

I. Maxillofacial Prosthetic Services

We are establishing national RVUs for these services and, therefore, are discontinuing pricing by individual carriers, effective January 1, 1996. We estimate that total expenditures for CPT codes 21079 through 21087 and codes G0020 and G0021 (replaced by CPT codes 21076 and 20177 in 1996), based on the RVUs will be approximately $2.4 million in calendar year 1996. The 1994 Medicare expenditures for these 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 will not increase because we are implementing 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 we estimate that the total expenditures for these services will 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 are expanding the definition of ''diagnostic'' mammography to include as candidates for this service asymptomatic men or women who have a personal history of breast cancer or a personal history of biopsy-proven benign 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 in these categories are already receiving diagnostic mammography services.

K. Two Anesthesia Providers Involved in One Procedure

We will apply the medical direction payment policy to the single procedure involving both the physician and the CRNA. We will not 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 services as possible and receiving the same allowance they would have in the absence of this new policy.

L. Rural Hospital Impact Statement

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the Regulatory Flexibility Act. For purposes of section