# PART 413—[AMENDED]

9. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

#### § 413.5 [Amended]

10. In § 413.5(c)(9), the phrase "(as described in § 405.465 of this chapter) where elected as provided for in § 405.521 of this chapter." is removed, and the phrase "(as described in § 415.162 of this chapter) if elected as provided for in § 415.160 of this chapter." is added in its place.

## §413.13 [Amended]

11. In § 413.13(g)(1)(i), the phrase "§§ 405.480 through 405.482" is removed, and the phrase "§§ 415.55 through 415.70" is added in its place.

## § 413.80 [Amended]

12. In  $\S$  413.80(h), the phrase ", as described in  $\S$  414.450 of this chapter," is removed.

## § 413.86 [Amended]

- 13. In § 413.86, the following changes are made:
- a. In paragraph (b), in the definition of "Approved medical residency program" in paragraph (1), "§ 405.522(a)" is removed, and
- "§ 415.200(a)" is added in its place.b. In paragraph (g)(1)(ii),"§ 405.522(a)" is removed, and"§ 415.200(a)" is added in its place.

## § 413.174 [Amended]

14. In § 413.174(b)(4)(iv), the phrase "§§ 405.465 through 405.482" is removed, and the phrase "§§ 415.55 through 415.70, § 415.162, and § 415.164" is added in its place.

## PART 414—[AMENDED]

#### § 414.58 [Amended]

- 15. In § 414.58, the following changes are made:
- a. In paragraph (a), the phrase "§§ 405.550 through 405.580" is removed, and the phrase "§§ 415.100 through 415.130, and § 415.190" is added in its place.
- b. In paragraph (b), the phrase "\$ 405.465 of this chapter if the hospital exercises the election described in \$ 405.521(c)(2) of this chapter" is removed, and the phrase "\$ 415.162 of this chapter if the hospital exercises the election described in \$ 415.160 of this chapter" is added in its place.

# PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

16. The authority citation for part 417 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), secs. 1301, 1306, and 1310 of the Public Health Service Act (42 U.S.C. 300e, 300e–5, and 300e–9); and 31 U.S.C. 9701.

### § 417.554 [Amended]

17. In § 417.554, the phrase "§ 405.480, part 412 of this chapter, and §§ 413.55 and 413.24" is removed, and the phrase "part 412, §§ 413.24, 413.55, and 415.55" is added in its place.

# PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

18. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

## § 489.20 [Amended]

19. In § 489.20(d)(1), "§ 405.550(b)" is removed, and "§ 415.102(a)" is added in its place.

# § 489.21 [Amended]

20. In  $\S$  489.21(f), " $\S$  405.550(b)" is removed, and " $\S$  415.102(a)" is added in its place.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 28, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: December 1, 1995.

Donna E. Shalala,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A—Explanation and Use of Addenda B Through E

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physician services furnished in 1995. Addendum B contains the RVUs for work, practice expense, and malpractice expense, and other information for all services included in the physician fee schedule. Addendum C provides interim RVUs and related information for codes that are subject to comment. Each code listed in Addendum C is also included in Addendum B. Further explanations of the information in these addenda are provided at the beginning of each addendum.

To compute a fee schedule amount according to the formula provided in the final rule, use the RVUs listed in Addendum B and the GPCIs for 1996 listed in Addendum D of this final rule. In applying the formula, use the appropriate CF: For services designated as surgical, use a CF of \$40.7986. For primary care services, use a CF of \$35.4173. For other nonsurgical services, use a CF of \$34.6293.

Addendum D lists the GPCIs for 1996. Addendum E lists the procedure codes subject to the site-of-service differential.

Addendum B—1996 Relative Value Units and Related Information Used in Determining Medicare Payments for 1996

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysician services or items), or L (orthotics), and codes for anesthesiology.

- 1. *CPT/HCPCS code*. This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at
- the end of this addendum.
- 2. Modifier. A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier 26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code: One for the global values (both professional and technical); one for modifier 26 (PC); and one for modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.
- 3. *Status indicator*. This indicator shows whether the CPT/HCPCS code is in the physician fee schedule and whether it is separately payable if the service is covered.
- A = Active code. These codes are separately payable under the fee schedule if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national decision regarding the coverage of the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
- B = Bundled code. Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)
- C = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.
- D = Deleted code. These codes are deleted effective with the beginning of the calendar year.