(b) *Authority to appoint FCCs.* (1) The Chief, Claims and Tort Litigation Staff, has the delegated authority to appoint a judge advocate or civilian attorney as a FCC and to redelegate all or a part of his or her settlement authority to that FCC.

(2) A settlement authority appointed as a FCC in paragraph (a) of this section may appoint one or more subordinate judge advocates or civilian attorneys as FCCs, and may redelegate all or part of that settlement authority to those FCCs, in writing. Every FCC must have authority to settle claims for at least $10,000.

* * * * *

§ 842.84 [Amended]

4. In § 842.84 paragraphs (a)(2) and (b)(3) are amended to remove the entry "$10,000" and to add in its place "$100,000." Paragraphs (a)(2)(iv) and (b)(3)(iv) are amended to remove the words "and Branch Chiefs," and remove the comma and add the word "and" between "The Chief," and "Deputy Chief."

5. Section 842.89 is amended to revise paragraph (a) and (d) to read as follows.

§ 842.89 Statute of limitations.

* * * * *

(a) Federal, not state law, determines the time of accrual. A claim normally accrues at the time of injury when essential operative facts are apparent. However, in other instances, especially in complex medical malpractice cases, a claim accrues when the claimant discovers or reasonably should have discovered the existence of the act that resulted in the claimed loss.

* * * * *

(d) Properly asserted third party actions, as permitted under the Federal Rules of Civil Procedure, may be brought against the United States without first filing a claim. In such instances those actions may start more than 2 years after the claim has accrued.

6. Section 842.95 is amended to revise paragraph (b) to read as follows.

§ 842.95 Non-assertable claims.

* * * * *

(b) Loss or damage to government property:

(1) Caused by a nonappropriated fund employee acting in the scope of employment.

(2) For which a person has accountability and responsibility under the Report of Survey system.

* * * * *

7. Section 842.109 is amended to revise paragraph (d) to read as follows:

§ 842.109 Claims payable.

* * * * *

(d) Claims filed by ANG military or civilian health care providers or legal personnel for their personal liability by settlement or judgement, to include reasonable costs of such litigation, for their common law tortious acts committed on or after 29 Dec 1981 while performing title 32 duty within the scope of their employment under the circumstances described in 10 U.S.C. 1089(f) and 10 U.S.C. 1054(f).

Patsy J. Conner,

Air Force Federal Register Liaison Officer.

[FR Doc. 90-18412 Filed 8-6-90; 8:45 am]

BILLING CODE 3910-01-M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 165

[Regulation 90-10]

COTP Huntington, WV; Safety Zone Regulation: Ohio River Mile 184.0 to 185.0

AGENCY: Coast Guard, DOT.

ACTION: Emergency rule.

SUMMARY: The Coast Guard is establishing a safety zone between mile 184.0 and 185.0 Ohio River. The zone is needed to protect waterborne traffic from a potential hazard associated with a fireworks display located at mile 184.5 Ohio River. Entry into this zone is prohibited unless authorized by the Captain of the Port.

EFFECTIVE DATE: This regulation becomes effective at 2130 (local time) 18 August 1990. It terminates 2230 (local time) 18 August 1990, unless terminated sooner by the Captain of the Port.

FOR FURTHER INFORMATION CONTACT: CWO Pierce, Huntington, WV (304) 529-5524.

SUPPLEMENTARY INFORMATION: In accordance with 5 U.S.C. 553, a notice of proposed rulemaking was not published for this regulation and good cause exists for making it effective in less than 30 days from the date of publication. Publishing an NPRM and delaying its effective date would be contrary to the public interest since immediate action is needed to prevent potential injury to waterborne personnel.

Drafting Information

The drafter of this regulation is CWO Pierce, project officer for the Captain of the Port.

Discussion of Regulation

The incident requiring this regulation results from a potential hazard associated with a fireworks display located at mile 184.5 Ohio River. This regulation is issued pursuant to 33 U.S.C. 1225 and 1231 as set out in the authority citation for all of 33 CFR part 165.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Security measures, Vessels, Waterways.

Regulation

In consideration of the foregoing, subpart C of part 165 of title 33, Code of Federal Regulation, is amended as follows:

PART 165—[AMENDED]

1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1225 and 1231; 50 U.S.C. 191; 49 CFR 1.46 and 33 CFR 1.05-1(g), 6.04-1, 6.04-6 and 160.5

2. A new section 165.T0279 is added to read as follows:

§ 165.T0279 Safety Zone Ohio River.

(a) *Location.* The following area is a safety zone: Mile 184.0 to 185.0 Ohio River.

(b) *Effective date.* This regulation becomes effective on 18 August 1990 at 2130. It terminates on 18 August 1990 at 2230, unless terminated sooner by the Captain of the Port.

(c) *Regulations.* In accordance with the general regulations in § 165.23 of this part, entry into this zone is prohibited unless authorized by the Captain of the Port.

Dated: 20 July 1990.
Time: 1300.

R.P. Prince,

LCDR, U.S. Coast Guard, Alternate Captain of the Port, Huntington, West Virginia.

[FR Doc. 90-18390 Filed 8-6-90; 8:45 am]

BILLING CODE 4910-14-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 61

[FRL-3818-2]

National Emission Standards for Hazardous Air Pollutants

AGENCY: Environmental Protection Agency.

ACTION: Notice of delegation.

SUMMARY: On April 30, 1990, the Metropolitan Government of Nashville-Davidson County, Tennessee, requested delegation of authority for the

implementation and enforcement of two new standards in 40 CFR part 61 (National Emission Standards for Hazardous Air Pollutants (NESHAP)). In a letter dated June 18, 1990, EPA delegated the new standards to the Nashville-Davidson County, Metropolitan Health Department.

DATES: The effective date of delegation is June 18, 1990.

ADDRESSES: Copies of the request for delegation of authority and EPA's letter of delegation may be examined during normal business hours at the Agency's regional office, 345 Courtland St., NE., Atlanta, Georgia 30365. All reports required pursuant to the newly delegated standards (identified below) should be submitted to the Metropolitan Health Department, Air Pollution Control Division, 311–23rd Avenue, North, Nashville, Tennessee 37203.

FOR FURTHER INFORMATION CONTACT: Carla E. Pierce of the EPA Region IV Air Programs Branch at the above address and telephone number 404–347–2864 or FTS–257–2864.

SUPPLEMENTARY INFORMATION: Section 112(d)(1) of the Clean Air Act (CAA) authorizes EPA to delegate to the states the authority to implement and enforce the standards set out in 40 CFR part 61, NESHAP.

On Aril 30, 1990, the Metropolitan Health Department of Nashville/Davidson County requested the delegation of two NESHAP categories. The following NESHAPS were requested:

40 CFR Part 61 Subpart

BB—Benzene Emissions (Benzene Transfer Operations)
FF—Benzene Emissions (Benzene Waste Operations)

After thorough review of the request, the Regional Administrator determined that such delegation was appropriate with all the conditions set forth in the initial delegation letters of February 20, 1986, and May 25, 1977. EPA, thereby, delegated its authority for 40 CFR part 61, subparts BB and FF (excluding § 61.353) on June 18, 1990. Subpart FF contains a delegation restriction under § 61.353 for alternative means of emission limitation.

I certify, pursuant to 5 U.S.C. 605(b), that this delegation will not have a significant impact on a substantial number of small entities.

The Office of Management and Budget has exempted this rule from the requirement of section 4 of Executive Order 12291.

Authority: Section 112 of the Clean Air Act, as amended (42 U.S.C. 7412).

Dated: July 23, 1990.

Joe R. Franzmathes,

Acting Regional Administrator.

[FR Doc. 90–18451 Filed 8–6–90; 8:45 am]

BILLING CODE 6560–50–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 405

[BPD–480–F]

RIN 0938–AD63

Medicare Program; Uniform Relative Value Guide for Anesthesia Services Furnished by Physicians

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: We are establishing a relative value guide for use in all carrier localities in making payment for anesthesia services furnished by physicians under Medicare Part B. This final rule implements section 4048(b) of the Omnibus Budget Reconciliation Act of 1987. The relative value guide is designed to ensure that payments using the guide do not exceed the amount that would have been paid absent the guide.

This final rule also implements section 6106 of the Omnibus Budget Reconciliation Act of 1989. Section 6106 revises the method under which time units are determined for anesthesia services furnished by anesthesiologists or certified nurse anesthetists on or after April 1, 1990.

DATES: This final rule is effective September 6, 1990.

FOR FURTHER INFORMATION CONTACT: James Menas, (301) 966–4507.

SUPPLEMENTARY INFORMATION:

I. Background

Prior to the implementation date of this final rule and in accordance with our regulations (42 CFR 405.552 and 405.553), anesthesiology services personally furnished by a physician were paid on a reasonable charge basis under Part B of the Medicare program (Supplementary Medical Insurance). In addition, payment on a reasonable charge basis under Medicare Part B could be made for the physician's personal medical direction that he or she provided to qualified individuals furnishing anesthesia services (for example, a certified registered nurse anesthetist (CRNA)).

Medicare carriers processing anesthesia claims calculated the reasonable charge for anesthesia services based on the following:

- Base value units assigned to the specific procedure performed that represent the value of all anesthesia services except the value of the actual time spent administering the anesthesia.
- Time units that represent the elapsed period of time from when the anesthesiologist prepares the patient for induction and ending when the anesthesiologist is no longer in personal attendance to the patient. The carrier allowed no more than one time unit for each 15-minute or 30-minute interval.
- The carrier could also use modifier units that take into account special factors such as the age or physical condition of the patient. About 65 percent of the carriers recognized modifier units.

On December 22, 1987, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100–203) was enacted. Section 4048(b) of Public Law 100–203 requires the Secretary, in consultation with groups representing physicians who furnish anesthesia services, to establish a relative value guide for use in all carrier localities in making payment under Medicare Part B for physician anesthesia services furnished on or after January 1, 1989. The guide must be designed to result in payments that do not exceed the amount of the expenditures that would have occurred absent this provision of the law. On January 26, 1989 (54 FR 3794), we published a proposed rule to implement the provisions of section 4048(b) of Public Law 100–203.

II. Provisions of the Proposed Rule

A. Relative Value Guide and Coding Issues

In processing anesthesia claims, carriers previously had the authority to choose the relative value guide they used for assigning base units to anesthesia services. The principal relative value guides included various versions of the American Society of Anesthesiologists' (ASA) Relative Value Guide, particularly the 1967, 1970, and 1973 versions of that guide; the 1964 or the 1969 California Relative Value Scale; various State guides; and charge-based relative value guides. These guides assign anesthesia relative value base units to surgical procedures. Because of this, our carriers have required physicians to report the anesthesia service using the surgical procedure codes from the Physicians Current Procedural Terminology, Fourth Edition, commonly referred to as CPT–4.

The CPT–4 also includes an anesthesiology coding system developed by ASA that categorizes anesthesia procedures by body part. There are 17 broad categories ranging from anesthesia procedures on the head to anesthesia procedures associated with miscellaneous procedures. These categories are composed of approximately 250 codes. This compares with up to 4200 surgical procedure codes under which carriers previously classified anesthesia services.

ASA has also developed a relative value guide to complement the CPT–4 anesthesia codes that assigns a specific number of base units to each of the anesthesia codes. ASA's relative value guide also provides for the use of modifier units for physical status and additional units for qualifying circumstances.

We proposed that the 1988 ASA Relative Value Guide be used as the uniform guide for making payment under Medicare Part B for anesthesia services furnished by physicians. One of our primary considerations in making this proposal is the fact that the 1988 ASA Relative Value Guide is linked to the CPT–4 anesthesia codes. All other relative value guides are linked to the surgical procedures. Also, the number of procedure codes under this system is significantly less than under the previous system. In addition, the 1988 ASA Relative Value Guide is designed to lend itself to determining relative value units for new procedures. Because the ASA guide is more oriented to grouping surgical procedures by body systems rather than oriented to the specific surgical procedure furnished, a relative value ordinarily can be assigned to a new procedure based on the existing relative value unit for the code in the body system category that is most comparable to the new procedure.

However, we also proposed to reduce the number of base units assigned to all lens surgery to four units. Under the ASA guide, lens surgery has a unit value of six. On October 7, 1986, we published a final notice in which we uniformly reduced the number of base units for cataract surgery from eight units to four units (51 FR 35693). We proposed to continue this policy. Also, in that final notice, we had reduced the number of base units for iridectomy anesthesia to four units. Under ASA's system, iridectomy anesthesia would be reported under "Anesthesia for procedures on eye; not otherwise specified." This category of services is currently assigned a base unit of five units. We proposed to require carriers to continue to recognize four base units for iridectomy anesthesia and establish a specific code for iridectomy anesthesia.

We proposed to allow carriers that previously recognized additional payments beyond the anesthesia fee for specialized forms of monitoring, such as intra-arterial, central venous, and Swan-Ganz, to continue this practice. Carriers who did not previously recognize additional payment for specialized forms of monitoring would be required to maintain their previous practice. We were concerned, however, that the continuation of this practice would result in payment policies that are not uniform for services that represent an integral part of the anesthesia service for a surgical patient. Therefore, we requested comments on the option of *not* recognizing separate reasonable charge payments for specialized monitoring, but rather, including payment for specialized monitoring through the anesthesia conversion charge factor.

While we proposed the use of CPT–4 anesthesia codes, we considered requiring the continuation of CPT–4 surgical codes to report anesthesia services. We invited comment on the extent to which the CPT–4 anesthesia codes could be modified to prevent inappropriate coding or fragmentation of services and more readily permit the detection of noncovered services.

B. Modifier Units

Modifier units are units allowed in addition to the base units assigned to a procedure and are based on the patient's physical status (for example, one or more units may be added if the patient has a severe systemic disease). Additional units are allowed for qualifying circumstances, such as extreme age, unusual risk factors, or less than optimum operating conditions.

The use of modifier units appears to be subjective and difficult for carriers to validate in claims review operations without substantial cost and effort. ASA proposed to refine the circumstances under which modifier units are recognized and has drawn up revised guidelines that define more precisely the specific patient conditions that warrant modifier units. Nevertheless, we proposed that no modifier units or any other units for qualifying circumstances would be recognized under the uniform relative value guide. In the proposed rule, we stated that we believe that the elimination of modifier units would not have a substantial adverse effect on individual anesthesiologists for the following reasons:

- About 35 percent of the carriers do not recognize modifier units. Therefore, anesthesiologists in these carriers' areas would not experience any change.
- We estimated that the proportion of total anesthesia units associated with modifier units is relatively minor, less than 10 percent of total units.
- Anesthesiologists typically treat a mix of patients with different health conditions. It is unlikely that an anesthesiologist would treat only patients in poor physical health and, therefore, would be disadvantaged by the elimination of modifier units.

In addition, we believe that it would be difficult to preserve budget neutrality if we allowed the use of modifiers because each carrier would have had to estimate the number of modifier units it would have allowed if ASA's revised modifier unit policy had been used to process claims in 1988. Finally, we were concerned with the precedent that could be established with respect to other physician specialties and the use of modifiers with respect to Medicare cases.

C. Time Units

In the proposed rule, we stated that we were interested in receiving comments on whether the adoption of the CPT–4 anesthesia codes would lessen or enhance our ability to eliminate the use of time units. Although we presented a number of considerations that would support the elimination of time units, we proposed to retain the use of time units at this point.

We described the recommendations made by the Office of Inspector General (OIG) to change the way an anesthesia time unit is computed. The options were presented by OIG in a report entitled "Medicare Part B Payments for Unexpended Physician Efforts Relating to Anesthesia Services" (A–07–88–00082 issued on August 9, 1988). (Copies of this report can be obtained by writing to OIG at 330 Independence Ave. SW., Washington, DC 20201.) The options were as follows:

- Pay for actual time expended, rather than treating all fractional units as whole units. That is, 65 minutes would equal four and one-third time units instead of five units for a procedure personally performed by an anesthesiologist.
- Round all fractional units down to the next lower whole unit, that is, disregard all fractional time units. (For example, any amount of time between 61 and 74 minutes would equal four units instead of five units.)
- Pay only for those fractional units in excess of one-half as whole units. That is, any fraction equal to or less than one-half time unit (7.5 minutes) would be disregarded. (For example, 65 minutes

would equal four units, but 68 minutes would equal five units.)

We specifically requested comments on these alternatives.

In the preamble to the proposed rule, we stated our intention to initiate more aggressive monitoring of time reporting in the future and to eliminate the separate time unit element of the anesthesia payment system within 2 years of the effective date of this final rule. We indicated that the elimination of time units will be the subject of a separate notice of proposed rulemaking and that comments submitted in response to that proposed rule will be carefully considered before implementation of a revised time unit policy.

D. Program Expenditures Under the Uniform Relative Value Guide

Section 4048(b) of Public Law 100–203 provides that the uniform relative value guide is to be designed so as to result in Medicare payments for anesthesia services that do not exceed the amount that would have occurred absent the guide. In order to comply with this statutory requirement, we proposed that carriers adjust their customary and prevailing charges during the profile update process for 1989. Customary and prevailing charges would be computed as if the 1988 ASA Relative Value Guide, without modifiers, had been used to process claims for services furnished during the 12-month period ending June 30, 1988. This is the 12-month period that was used to update the customary and prevailing charges on January 1, 1989. For carriers unable to make this adjustment as part of the profile update process because, for example, time and modifier units are merged, we proposed that they make the adjustment based on a representative sample of anesthesia services.

The prevailing charge as limited by the Medicare economic index would be adjusted by the ratio of the unadjusted prevailing charge under the new system to the unadjusted prevailing charge under the old system.

Revised maximum allowable actual charges (MAACs) would be calculated by multiplying the previous year's MAAC by the ratio of the updated customary charge determined under the carrier's previous system to the updated customary charge determined under the uniform relative value guide. However, carriers that adjusted conversion factors based on a representative sample of anesthesia claims would use the sample results to calculate revised MACCs.

E. Delay in the Effective Date of the Uniform Relative Value Guide

We proposed to delay the implementation of the uniform relative value guide until March 1, 1989. Thus, for services furnished on or after January 1, 1989 and before March 1, 1989, anesthesia services would continue to be paid on the basis of CPT–4 surgical codes and under the carrier's relative value guide. The carriers would update customary and prevailing charge conversion factors on January 1, 1989 in the usual manner.

We proposed the delay to allow the carriers additional time to recalculate customary and prevailing charge conversion factors applicable under the uniform relative value guide. In addition, since HCPCS was updated in March 1989, the delay enabled carriers to implement the coding change and the conversion factors under the uniform relative value guide at the same time. We believe that the additional time provided for a more orderly transition.

R. Updating the Uniform Relative Value Guide

In the proposed rule, we discussed the process by which the relative value guide is to be reviewed and revised. The ASA advised us that they have made few annual revisions to their Relative Value Guide.

We would review the guide to determine if the following changes are needed:

- The addition or deletion of codes to reflect new or outmoded procedures.
- The adjustment of base units for procedures for which there are measurable technical or practice changes, such as increased proficiency.

In the proposed rule, we provided that we would allow carriers to assign base units to new procedures as they are developed. The nature of the CPT–4 anesthesia codes is such that when new procedures are developed, the coding system generally will assign the new procedure to the body part code with which it is most closely associated. We assume that most new procedures would follow this route. Conversely, if there is no existing code that appropriately describes a new procedure, the carriers would, through their medical consultants, establish a local code and relative value. We proposed to review the carriers' practices with these procedures every 3 years and establish uniform relative values.

With regard to the adjustment of base units for procedures for which there are measurable technological or practice changes, we proposed to announce these adjustments through publication in the **Federal Register** of proposed and final notices as specified in the regulations at § 405.502(h), which concern the establishment of special reasonable charge limits for physician services. Section 1842(b)(10)(A)(i) of the Act specifically provides that when "inherent reasonableness" is used to reduce the reasonable charge for a service, a special charge limit is imposed. This limits the amount a nonparticipating physician could charge a beneficiary. During the first 12 months it is in effect, the limit would be equivalent to the limiting charge plus one-half of the difference between the physician's actual charge and the limiting charge. The limiting charge is defined as 1.25 multiplied by the reasonable charge for the anesthesia service. After the first 12 months, the charge limit would be equivalent to the limiting charge.

We proposed to review every 3 years the carriers' practices with those procedures for which there are measurable technological or practice changes and to establish uniform relative base units.

III. Discussion of Comments

We received approximately 530 comments on the proposed rule to implement the uniform relative value guide for physician anesthesia services. The majority of the comments were from individual anesthesiologists. In addition, we received comments from professional organizations that represent anesthesiologists or anesthetists such as the American Society of Anesthesiologists, the Anesthesia Care Team Society, and the American Association of Nurse Anesthetists. We also received comments from the American Medical Association (AMA), several State anesthesia societies and medical societies, Blue Cross and Blue Shield Association, other third party payers, the National Senior Citizens Law Center, and organizations involved in operating or managing health care delivery systems.

We received numerous comments concerning our intention to propose in the future to eliminte time units as a separate element of the anesthesia payment formula and to increase the base unit value to include the average number of time units per procedure. Under this policy, payment would be determined solely on the basis of base units and a dollar conversion factor. Since this change is not being implemented now, we will address these comments when we publish a proposed rule on this matter. The remaining

comments received and our responses to those specific comments follow:

A. Choice of a Uniform Relative Value Guide

Comment: We did not receive any comments that opposed our selection of the 1988 ASA Guide as the uniform relative value guide or any comments suggesting that we select another guide. However, a few anesthesiologists indicated that the base unit value for cataract anesthesia should be revised from the current value of four units to either six or eight units.

Response: As we noted in the proposed rule, on October 7, 1986, we published a final notice that, under the inherent reasonableness statutory authority, lowered the base unit value for cataract anesthesia to four units; the reduction was effective for cataract anesthesia services furnished on or after January 1, 1987. In enacting section 9334(b)(1) of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509), Congress ratified that action. Since none of the commenters presented any evidence to show a change in circumstance since Congress and HCFA's prior action, we are not adopting this comment.

To accommodate the lower base unit value for anesthesia associated with an iridectomy, we have developed a new code to report this procedure. This code is Q0045, Anesthesia for iridectomy, and it has a base unit value of four. The uniform relative value guide, which is set forth as the Appendix to this final rule, has been revised to include this code.

B. Use of CPT-4 Anesthesia Codes or CPT—4 Surgical Codes to Report Anesthesia Services

Comment: Virtually all the anesthesiologists, the anesthesia specialty groups, and the organized medical groups favored the use of CPT-4 anesthesia codes instead of CPT-4 surgical codes to report anesthesia services, primarily because billing would be simplified. These commenters stated that the level of detail in surgical code descriptors is needed for surgical services, but is not necessary for anesthesia services. Some commenters, however, objected to the requirement that anesthesiologists include diagnostic coding information on the claim or bill for physicians' services furnished on or after April 1, 1989 because that information must be obtained from the operating surgeon.

Two commenters specifically expressed reservations about the movement to CPT-4 anesthesia codes. One of these commenters (a Medicare carrier) opposed the use of CPT-4 anesthesia codes and indicated that while the law requires HCFA to develop a uniform relative value guide, it did not mandate the use of CPT-4 anesthesia codes. The commenter also stated that the use of CPT-4 codes would result in the loss of information necessary to detect specific noncovered services, such as cosmetic surgery and medically unnecessary anesthesia procedures. As an alternative, this commenter suggested that we require the concurrent reporting of both the surgical and the anesthesia codes. The other commenter did not specifically object to the adoption of CPT-4 anesthesia codes but did not see any significant practical improvement to justify the change.

Response: We agree that section 4048(b) of Public Law 100-203 requires us to develop a uniform relative value guide but is silent on the use of coding systems. Operationally, we could link the ASA's base unit values to either the surgical code or the anesthesia code. We chose anesthesia codes. As we noted in the proposed rule (54 FR 3795), on February 1, 1983, we signed an agreement with the AMA to permit the Medicare and Medicaid programs to use the AMA's copyrighted CPT-4 for reporting physicians' services. As a result of that agreement, we adopted most of the medicine, surgery, radiology, pathology, and laboratory codes. At that time, however, we did not adopt the anesthesia codes because we thought it would be difficult for the carriers to ensure that the use of CPT-4 anesthesia codes would not result in higher program expenditures. Upon further review, we believe that we have been able to implement the relative value guide using CPT-4 anesthesia codes in a manner that will not increase program expenditures in the shortrun.

In the proposed rule, we expressed some concern that the decrease in the number of codes to report anesthesia services could lead to a loss of coding information and carriers might be unable to make proper coverage decisions in all cases. We pointed out in that document that the use of diagnosis codes as required by section 202(g) of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360) and the performance of postpayment services by carriers would help alleviate the problem of a loss of coding information. Furthermore, we will continue to work in cooperation with the ASA to develop additional codes to describe specific or general noncovered anesthesia services. We believe these initiatives will improve the CPT-4 anesthesia coding system and prevent payment for inappropriate anesthesia services.

We recently completed an analysis of surgical services that are generally not covered under Medicare to determine if there are anesthesia codes in existence for them which would permit carriers to identify and refuse payment on claims with respect to anesthesia related to noncovered procedures. We found that the CPT-4 anesthesia coding system does not include a separate code for blepharoplasty, which is generally not a covered service. Therefore, a separate anesthesia code must be developed for this procedure. The other noncovered procedures identified by our study are not high volume services, and thus, do not need a separate code.

We have established a new HCPCS code of Q0047 for "Anesthesia for blepharoplasty." This code is included in the final relative value guide set forth as the Appendix to this final rule. We are also including code 01996 "Daily hospital management of epidural or subarachnoid drug administration". This code replaces 99154 which had the same description as 01996 but was included in the Medicine category of CPT-4. The carrier's payment allowances for this code should be the lesser of the carrier's reasonable charge payment for code 99154, if the carrier paid this code under regular reasonable charge rules, or the product of three base units and the reasonable charge conversion factor.

With respect to those commenters who objected to the requirement that the diagnostic codes be included on the claim or bill for physicians' services, the requirement is mandated by the statute, and we do not have the authority to remove it. We are implementing this requirement through a separate rulemaking document. However, instructions for completing bills and requests for payment were distributed to the carriers on March 3, 1989. The carriers have sent this information to the physicians that they serve either through a newsletter or a bulletin.

C. Elimination of Modifier Units

We received comments on the elimination of modifier units, in general, and specific comments on the elimination of modifier units for certain circumstances, such as age or physical health status. The majority of commenters were anesthesiologists who favored the general use of modifier units for patient physical status. With a few exceptions, their comments were directed to the current carrier modifier system and not the more refined system proposed by the ASA. Those who supported physical status modifiers almost always indicated that physical status modifiers better measure

anesthesia risk and complexity of illness. Thus, modifiers make the system patient specific and more appropriately compensate for increased anesthetic risk. Several organizations recommended the general elimination of modifier units. We have addressed specific issues raised on modifier units below.

Comment: One commenter indicated that the use of modifiers in circumstances where the patient is age 70 or more without regard to the patient's actual physical condition or medical status is in violation of the Age Discrimination Act of 1975.

Response: We do not agree with the commenter that previous payment policy violated the Age Discrimination Act of 1975. Moreover, this regulation, which eliminates the use of modifiers, clearly cures whatever defect the commenter complained of with respect to prior policy.

Comment: One commenter stated that nothing in the provisions of section 4048(b) of Public Law 100–203 or the Conference Committee Report that accompanied the law suggests that Congress intended that modifier units be eliminated. In fact, the commenter indicated that the Committee Report specifically refers to the use of modifier units in determining payment for anesthesia services.

Response: We agree with the commenter that the law is silent on the issue of modifier units and whether modifier units are to be incorporated as an element of the uniform relative value guide. However, the reference in the Committee Report to modifier units is in context of an explanation of the provisions of the law with respect to a payment policy for anesthesia services prior to enactment of Public Law 100–203 (H.R. Rep. No. 495, 100th Congress, 1st Sess. 600 (1987)). It accurately explains that some carriers recognize adjustments relating to the patient's age or physical condition. Since the law is silent concerning modifier units, we believe we have the authority to eliminate their use under the relative value guide system.

Comment: Many commenters indicated that the elimination of modifier units will produce unfair redistributive results. Anesthesiologists in teaching hospitals or tertiary care centers or those who specialize in cardiac anesthesia and who treat more complex cases will be penalized while anesthesiologists whose patient mix contains a greater percentage of healthy Medicare patient will gain. Some anesthesiologists included in their comments anecdotal cases justifying the need for physical status modifiers for patients with certain medical problems.

Response: We do not have any evidence that anesthesiologists in teaching hospitals or those who specialize in certain cases will be disadvantaged significantly by the elimination of modifier units. In fact, one commenter, a State anesthesiology society, indicated that the nonrecognition of modifier units would be balanced by the payment of time units because those factors that are the basis for modifier units are generally factors that contribute to the length of time required for the anesthesia procedure. We note that the present system under which modifiers are recognized for age and physical status in addition to both time units and base units may result in a methodology that overvalues the amount recognized for some anesthesia services.

We also note that carriers in the New England region, the Middle Atlantic region, and the States of Florida and Michigan have not recognized modifier units. However there has not been any significant number of complaints from anesthesiologists in teaching hospitals in these areas that they have been negatively affected by the absence of modifier units. Therefore, as we stated in the proposed rule, we believe that the elimination of modifier units will not have a substantial adverse impact on individual anesthesiologists.

Comment: In its comment, the ASA advanced a proposal for instituting a uniform modifier unit policy that would achieve overall budget neutrality. Under the proposal, the age modifier and some other modifiers would be eliminated and physical status modifiers would be restructured. The ASA suggested that the budget savings associated with the elimination of age and some other modifiers and restructured physical status modifiers for those carriers that currently recognize modifiers would more than offset the increased expenditures for those carriers that would begin to recognize physical status modifiers.

Response: Policy considerations aside, we lack the data to conclusively prove that the ASA proposal will, indeed, be budget neutral or produce budget savings. A major problem is predicting the number of modifier units that would have been paid if the carriers had used the more refined ASA system previously. It would be equally difficult to measure the savings that would flow from the difference between the more refined system and the carriers' previous systems.

We are also concerned about inconsistency in method between this approach and ours. We instructed the carriers to maintain budget neutrality at the locality level to minimize the financial impact on anesthesiologists. The modifier unit approach suggested by ASA would attempt to maintain budget neutrality or produce saving at the national level. It would produce increases in payments for anesthesia services for those carriers that have not previously recognized modifiers. There could also be significant changes in payment for those carriers whose modifier unit policy was considerably more generous than that proposed by the ASA.

D. Separate Payments for Insertion of Arterial Lines, Central Venous Pressure Lines, and Swan-Ganz Catheters

Comment: Some anesthesiologists pointed out that the additional payments made for specialized monitoring such as intra-arterial, central venous, and Swan-Ganz are made based on the technical service; that is, the insertion of the arterial or central venous pressure line or a Swan-Ganz catheter. Additional payments are not made for specialized monitoring.

Response: The CPT–4 codes that describe the placement of lines are—

—Right heart catheterization, placement of flow directed catheter with or without balloon tip when placed for monitoring purposes, collection of blood, angiography (93503);

—Placement of central venous catheter (36488, 36489, 36490, 36491); and

—Arterial catheterization (36620, 36625, 36640, 36669).

When separate payment is made for these codes, payment is made for the placement or insertion of the line or catheter and not for the monitoring function that subsequently follows. Since these codes are listed under the medical or surgical procedure coding section, we are not viewing these services as anesthesia services subject to the uniform relative value guide. We are concerned, however, that these procedures are often performed together with other anesthesia services for a patient by the anesthesiologist. We will study the manner in which payment for these services might be integrated in the payment for anesthesia services.

Comment: Anesthesiologists and the professional organizations that represent them opposed the elimination of separate payments for placement of arterial, central venous, and Swan-Ganz lines. They recommend that anesthesiologists be paid separately just as other specialists, such as cardiologists or surgeons, for the insertion of lines or catheters for

specialized monitoring. The ASA recommended that these services be paid on the basis of uniform national base units that are listed in the ASA's relative value guide.

Response: As noted in the previous response, these services are not considered anesthesia services under the CPT–4 coding system. Therefore, they are, by definition, not relevant services subject to the uniform relative value guide for anesthesia services. We are deferring the development of a uniform policy for these services for all specialists who furnish the services. In the meantime, the carriers should continue their existing policies with regard to payment for these services.

E. Updating the Uniform Relative Value Guide

We received comments concerning the frequency of the update (for example, annually), the actual process by which revisions would occur, and the manner in which HCFA would communicate these revisions. The commenters' specific concerns are addressed below.

Comment: One commenter recommended that changes in the uniform relative value guide be handled once every year or 2 years.

Response: We proposed that the carriers establish base units for new procedures for which there is no established anesthesia code as they are developed. We also proposed to review carriers' experiences with this process every 3 years for the purpose of establishing uniform base unit values for these new procedures. We also stated in the proposed rule that we would propose revisions to base units for procedures where measurable technological changes have occurred on an "as needed" basis. Based on the comments we received and further analysis of how this process would work, we have decided to handle both types of updates on an "as needed" basis.

As needed, we will assemble a panel of medical advisors from both HCFA and the carriers who will review the base units assigned to established procedures to make sure the number of units assigned to the procedures still accurately reflect the value of the anesthesia services. At the same time, we will review the carriers' experience in assigning base units for new procedures, and establish a uniform national procedure code and base unit value for those new procedures. The results of this review will be published as a revision to the Medicare Carriers Manual (HCFA-Pub. 14). We are revising the proposed new § 405.553(d)(3) to reflect this process.

Comment: The ASA recommended that an advisory committee be established, either under ASA's or HCFA's sponsorship, to review procedural changes on a regular basis and make recommendations to HCFA on a regular basis. ASA suggested that the committee be composed of representatives of anesthesia providers, consumers, and third-party payers, including the Federal Government.

Response: We do not favor this process. The ASA currently has in place an organized method for reviewing its base unit system. We support a system in which the ASA makes its conclusions available to us. In turn, as discussed above, we will assemble a panel of our medical advisors and carrier medical advisors as needed to review the ASA conclusions and make a final decision on the base unit values. We will then publish any changes to the base unit values through a revision to the Medicare Carriers Manual.

Comment: The ASA pointed out that adjustments in the uniform relative value guide for technological reasons, which we proposed to make under the inherent reasonableness authority in § 405.502(h), are different from the cataract anesthesia adjustments previously made under that authority. As a result, the ASA recommends that routine adjustments in the uniform relative value guide resulting from historical need to update the guide periodically be carried out independent of the inherent reasonableness process.

Response: We concur with the ASA's recommendation. As discussed above, we will make adjustments to base units for technological reasons as part of the revisions to the relative value guide. The special charge limit, also discussed above, will not apply where base unit values are lowered. Rather, nonparticipating anesthesiologists must adjust their charges by lowering their base unit values to the lower base unit values.

F. Time Units

We did not receive any comments on the various alternatives we proposed to the current time unit policy. However, one organization offered a different alternative, as summarized below.

Comment: One commenter suggested that time units be divided into a specified number of segments and fractional time units allowed accordingly. For example, the 15-minute interval commonly used to determine a time unit value would be divided into three 5-minute intervals. If the personally performed procedure extended beyond 15 minutes but less than 20 minutes, 1⅓ time units would be allowed. Similarly, if the personally performed procedure extended beyond 20 minutes but less than 25 minutes, 1⅔ time units would be allowed.

Response: Section 6106 of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) revises the method under which time units are determined for anesthesia services furnished by anesthesiologists or certified registered nurse anesthetists. Under section 6106 of Public Law 101–239, for anesthesia services furnished on or after April 1, 1990, a time unit is determined based on the actual time of the fractional time unit. Previously, a fractional time unit was counted as a full time unit. We discussed the method for calculating time units at length in the proposed rule; one of the alternatives we discussed was later embodied in section 6106 of Public Law 101–239. Since we previously solicited comments on this matter and the provisions in section 6106 of Public Law 101–239 are clear and, we believe, self-implementing, we are incorporating this provision in regulations without an additional comment period. We are illustrating below the calculation of a time unit from the actual time of a fractional time unit. We are instructing carriers to calculate time units to one decimal place.

Example: An anesthesiologist personally performs an anesthesia procedure on or after April 1, 1990. The procedure has a base unit value of six units and lasts 68 minutes or 4.5 time units. The reasonable charge conversion factor is $20. Thus, the reasonable charge for the anesthesia procedure in this particular instance is $210, that is, $20 × (6.0 + 4.5).

We are also revising § 405.553 to reflect the policy on fractional time units for anesthesia procedures that are personally performed or medically directed by an anesthesiologist. As a result of the fee schedule system implemented for services furnished by CRNAs on or after January 1, 1989, all medically-directed services furnished by anesthesiologists are paid on the basis of one time unit per 30 minutes of anesthesia time. We have included this policy in our revisions to § 405.553.

G. Maximum Allowable Actual Charges

As discussed in the proposed rule (54 FR 3797), in order to ensure that expenditures for anesthesia services do not increase under the uniform relative value guide the carriers had to recompute customary, prevailing, and maximum allowable actual charge conversion factors (MAACs) for anesthesia services. The carriers released these revised conversion

factors to anesthesiologists in March 1989.

Because anesthesiologists have often priced their services using a different relative value guide than that used by the carrier, we have given nonparticipating anesthesiologists a choice on the system they could use to ensure compliance with the MAAC program.

An anesthesiologist could use the MAAC given by the carrier and price his or her service in conjunction with the carrier's specific relative value guide and anesthesia policy guidelines. On the other hand, anesthesiologists who decided to use their own conversion factors to establish their charges were cautioned to use the same pricing guidelines they used in the April 1 through June 30, 1984 base period and to increase their conversion factors by no more than one percent per year throughout the period the MAACs remain in effect.

In moving to the ASA relative value guide for base unit purposes, we are using the guide that we have been informed is the one that is accepted and used by the majority of anesthesiologists. In addition, we have adjusted conversion factors, including MAAC conversion factors, to reflect the elimination of modifier units. In light of these considerations, we are no longer offering anesthesiologists the choice of using their system to ensure MAAC compliance. Compliance will be established in conjunction with the carrier's MAAC. As a result, anesthesiologists must no longer bill additional amounts for modifier units.

We will, however, allow an exception to this policy in those carrier areas where the carrier has not recognized modifier units for patient age and status of physical health. In these areas, the choice described above will still be available to the nonparticipating anesthesiologist.

The implementation of the actual time unit policy for fractional time intervals, effective for anesthesia services furnished on or after April 1, 1990, affects the application of the MAAC. To ensure compliance with the MAAC for anesthesia services furnished on or after April 1, 1990, the anesthesiologist must lower his or her MAAC charge or reflect the way a fractional time unit is determined.

IV. Regulatory Impact Statement

A. Executive Order 12291

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any final rule that meets one of the E.O. criteria for a "major rule"; that is, that will be likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Since none of the provisions being implemented in this final rule are expected to generate effects meeting one or more of the E.O. threshold criteria, we have not prepared a regulatory impact analysis.

B. The Regulatory Flexibility Act

In addition, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, all anesthesiologists are considered to be small entities.

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a final rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds located outside of a Metropolitan Statistical Area.

We did not receive any comments on the impact statements in the proposed rule, and none of the comments we received has caused us to significantly alter or revise the provisions of the proposed rule. Thus, the effects of this final rule are expected to be much the same as those we presented in the initial impact statement. In accordance with section 4048(b) of Public Law 100-203, we will require carriers to implement the new payment system in a manner such that payments under the uniform relative value guide do not exceed payments under the prior system. This rule does result in savings that are a result of the change in the time unit policy effective April 1, 1990, as required by Public Law 101-239; however, the savings are not due to the implementation of the relative value guide.

As a result of eliminating anesthesia modifier units, there may be some redistribution of payments from those anesthesiologists who used modifier units to those who did not use them. This redistributive effect will take place at the carrier "locality" level. There may be anesthesiologists within this locality who experience moderate increases or decreases in Medicare payments.

Based on the foregoing, we have determined and the Secretary certifies that this final rule will not have a significant effect either on a substantial number of small entities or small rural hospitals, we have not prepared either a regulatory flexibility analysis or an analysis of the effects of this rule on small rural hospitals.

List of Subjects in 42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR part 405, subpart E is amended as set forth below.

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart E—Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians

1. The authority citation for subpart E is revised to read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1834(b), 1842 (b) and (h), 1861 (b) and (v), 1862(a)(14), 1866(a), 1871, 1881, 1886, 1887, and 1889 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395l(a), 1395m(b), 1395u (b) and (h), 1395x (b) and (v), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww, 1395xx, and 1395zz).

2. Section 405.553 is amended by revising paragraphs (a), (b)(1)(i), (b)(2), and (c), and adding new paragraphs (d) and (e) to read as follows:

§ 405.553 Reasonable charges for anesthesiology services.

(a) *General rule.* In determining reasonable charge payment for anesthesiology services that meet the conditions in § 405.552(a), the carrier follows the rules in paragraph (b), (c), or (d) of this section, as applicable, and the rules in paragraph (e) of this section.

(b) *Services furnished before January 1, 1989 by the anesthesiologist or by an anesthetist employed by the anesthesiologist* (1)(i) The provisions of this paragraph apply to anesthesia

services furnished before January 1, 1989 by an anesthesiologist without the assistance of an anesthetist or to anesthesia services furnished to hospital outpatients or SNF or CORF patients by an anesthetist who is employed by an anesthesiologist.

* * * * *

(2) In determining reasonable charges for these anesthesia services, the carrier allows for no more than one time unit for each 15 minute interval, or fraction thereof, beginning from the time the physician or anesthetist begins to prepare the patient for induction of anesthesia, and ending when the patient may be safely placed under post-operative supervision and the physician or anesthetist is no longer in personal attendance.

* * * * *

(c) *Services furnished before January 1, 1989 by an anesthetist not employed by the anesthesiologist.* For services furnished before January 1, 1989, if the anesthetist who administers anesthesia under the direction of the anesthesiologist is not employed by the anesthesiologist, the carrier determines reasonable charges for the services by allowing no more than one time unit for each 30 minute interval, or fraction thereof, beginning from the time the anesthetist begins to prepare the patient for induction of anesthesia, and ending when the patient may be safely placed under post-operative supervision and the anesthetist is no longer in personal attendance.

(d) *Services furnished on or after January 1, 1989.*—(1) *Services personally furnished by an anesthesiologist.* (i) For anesthesia services furnished on or after January 1, 1989 but before April 1, 1990, if the anesthesiologist personally furnishes the service, the carrier determines reasonable charges for the services as described in paragraph (b)(2) of this section.

(ii) For determining reasonable charges for anesthesia services furnished on or after April 1, 1990, the carrier recognizes only the actual time of the fractional time interval.

(2) *Services medically directed by an anesthesiologist.* (i) For anesthesia services furnished on or after January 1, 1989 but before April 1, 1990, if the anesthesiologist medically directs procedures involving qualified anesthetists, the carrier determines reasonable charges for the services as described in paragraph (c)(2) this section.

(ii) For determining reasonable charges for anesthesia services furnished on or after April 1, 1990, the carrier recognizes only the actual time of the fractional time interval.

(e) *Use of a uniform relative value guide*—(1) *General rule.* For anesthesia services furnished by an anesthesiologist on or after March 1, 1989, the amount of payment for the service is determined based on a uniform relative value guide.

(2) *Selection of a uniform relative value guide.* The uniform relative value guide used is the 1988 American Society of Anesthesiologists' Relative Value Guide except that—

(i) The number of base units recognized for anesthesia services furnished during cataract or iridectomy surgery is four units;

(ii) Modifier units are not recognized; and

(iii) Base units associated with other than the Physicians' Current Procedure Terminology, Fourth Edition (CPT–4) anesthesia codes, such as those associated with medical or surgical services are not recognized.

(3) *Updating the uniform relative value guide.*—(i) *New procedures.* (A) For a new procedure that can be appropriately matched to an existing code, the carriers assign the new procedure to the existing code and the code's corresponding base unit value. HCFA does not review this type of code assignment.

(B) For a new procedure that cannot be matched to an existing code, the carriers establish a new procedure code and assign a base unit value to that new code. HCFA reviews the carriers' practices with new procedures that cannot be matched to existing codes as discussed in paragraph (e)(3)(ii) of this section.

(ii) *Revisions to current procedures and review of base units assigned to new procedures.* As needed, HCFA assembles a panel of its medical advisors and carriers' medical advisors to review revisions to base unit values for established procedures. In addition, HCFA reviews carriers' experiences with assigning base units for new procedures that cannot be matched to existing procedure codes. HCFA then establishes a uniform national code and a uniform national base unit value for each new procedure. The results of these reviews are published as a revision to the Medicare Carriers Manual.

(Catalog of Federal Domestic Assistance Program No. 13.774, Medicare—Supplementary Medical Insurance)

Dated: March 23, 1990.

Gail R. Wilensky,

Administrator, Health Care Financing Administration.

Approved: April 3, 1990.

Louis W. Sullivan,

Secretary.

Editorial Note: The following appendix will not appear in the Code of Federal Regulations.

Appendix—Uniform Relative Value Guide

CPT–4	Procedure	Base units
	HEAD	
00100	Anesthesia for procedures on intergumentary system of head and/or salivary glands, including biopsy; not otherwise specified.	5
00102	plastic repair of cleft lip	6
00104	Anesthesia for electroconvulsive therapy.	4
00120	Anesthesia for procedures on external, middle, and inner ear, including biopsy; not otherwise specified.	5
00124	otoscopy	4
00126	tympanotomy	4
00140	Anesthesia for procedures on eye; not otherwise specified.	5
00142	lens surgery	4
00144	corneal transplant	6
00145	vitrectomy	6
00148	ophthalmoscopy	4
00160	Anesthesia for procedures on nose and accessory sinuses; not otherwise specified.	5
00162	radical surgery	7
00164	biopsy, soft tissue	4
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified.	5
00172	repair of cleft palate	6
00174	excision of retropharyngeal tumor.	6
00176	radical surgery	7
00190	Anesthesia for procedures on facial bones; not otherwise specified.	5
00192	radical surgery (including prognathism).	7
00210	Anesthesia for intracranial procedures; not otherwise specified.	11
00212	subdural taps	5
00214	burr holes (For burr holes for ventriculography, see 01902.)	9
00216	vascular procedures	15
00218	Procedures in sitting position.	13
00220	spinal fluid shunting procedures.	10
00222	electrocoagulation of intracranial nerve.	6
	NECK	
00300	Anesthesia for all procedures on integumentary system of neck, including subcutaneous tissue.	5
00320	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified.	6
00322	needle biopsy of thyroid	3

APPENDIX—UNIFORM RELATIVE VALUE GUIDE—Continued

CPT-4	Procedure	Base units
	(For procedures on cervical spine and cord see 00600, 00604, 00670)	
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified.	10
00352	simple ligation	5
	(For arteriography; see radiologic procedure 01916)	
	THORAX (CHEST WALL AND SHOULDER GIRDLE)	
00400	Anesthesia for procedures on anterior integumentary system of chest, including subcutaneous tissue; not otherwise specified.	3
00402	reconstructive procedures on breast (e.g., reduction or augmentation mammoplasty, muscle flaps).	5
00404	radical or modified radical procedures on breast.	5
00406	radical or modified radical procedures on breast with internal mammary node dissection.	13
00410	electrical conversion of arrhythmias.	4
00420	Anesthesia for procedures on posterior integumentary system of chest, including subcutaneous tissue.	5
00450	Anesthesia for procedures on clavicle and scapula; not otherwise specified.	5
00452	radical surgery	6
00454	biopsy of clavicle	3
00470	Anesthesia for partial rib resection; not otherwise specified.	6
00472	thoracoplasty (any type)	10
00474	radical procedures (e.g., pectus excavatum).	13
	INTRATHORACIC	
00500	Anesthesia for all procedures on esophagus.	15
00520	Anesthesia for closed chest procedures (including esophagoscopy, bronchoscopy, thoracoscopy); not otherwise specified.	6
	(For transvenous pacemaker insertion, see 00530.)	
00522	needle biopsy of pleura	4
00524	pneumocentesis	4
00528	mediastinoscopy	8
00530	transvenous pacemaker insertion.	4
00540	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum; not otherwise specified.	13
00542	decortication	15
00544	pleurectomy	15
00546	pulmonary resection with thoracoplasty.	15
00548	intrathoracic repair of trauma to trachea and bronchi.	15
00560	Anesthesia for procedures on heart, pericardium, and great vessels of chest; without pump oxygenator.	15
00562	with pump oxygenator	20
00580	Anesthesia for heart or heart/lung transplant.	20

APPENDIX—UNIFORM RELATIVE VALUE GUIDE—Continued

CPT-4	Procedure	Base units
	SPINE AND SPINAL CORD	
00600	Anesthesia for procedures on cervical spine and cord; not otherwise specified.	10
	(For myelography and discography see radiological procedures 01906–01914.)	
00604	posterior cervical laminectomy in sitting position.	13
00620	Anesthesia for procedures on thoracic spine and cord; not otherwise specified.	10
00622	thoracolumbar sympathectomy.	13
00630	Anesthesia for procedures in lumbar region; not otherwise specified.	8
00632	lumbar sympathectomy	7
00634	chemonucleolysis	10
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., Harrington rod technique).	13
	UPPER ABDOMEN	
00700	Anesthesia for procedures on upper anterior abdominal wall; not otherwise specified.	3
00720	percutaneous liver biopsy	4
00730	Anesthesia for procedures on upper posterior abdominal wall.	5
00740	Anesthesia for upper gastrointestinal endoscopic procedures.	5
00750	Anesthesia for hernia repairs in upper abdomen; not otherwise specified.	4
00752	lumbar and ventral (incisional) hernias and/or wound dehiscence.	6
00754	omphalocele	7
00756	transabdominal repair of diaphragmatic hernia.	7
00770	Anesthesia for all procedures on major abdominal blood vessels.	15
00790	Anesthesia for intraperitoneal procedures in upper abdomen including bowel shunts; not otherwise specified.	7
00792	partial hepatectomy (excluding liver biopsy).	13
00794	pancreatectomy, partial or total (e.g., Whipple procedure).	8
00796	liver transplant (recipient)	30
	(For harvesting of liver, use 01990.)	
	LOWER ABDOMEN	
00800	Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified.	3
00802	panniculectomy	5
00806	Anesthesia for laparoscopic procedures.	6
00810	Anesthesia for intestinal endoscopic procedures.	6
00820	Anesthesia for procedures on lower posterior abdominal wall.	5
00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified.	4
00832	ventral and incisional hernias.	6

APPENDIX—UNIFORM RELATIVE VALUE GUIDE—Continued

CPT-4	Procedure	Base units
00840	Anesthesia for intraperitoneal procedures in lower abdomen; not otherwise specified.	6
00842	amniocentesis	4
00844	abdominoperineal resection.	7
00846	radical hysterectomy	8
00848	pelvic exenteration	8
00850	cesarean section	7
00855	cesarean hysterectomy	8
00857	Continuous epidural analgesia, for labor and cesarean section.	7
00860	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified.	6
00862	renal procedures, including upper ⅓ of ureter or donor nephrectomy.	7
00864	total cystectomy	8
00866	adrenalectomy	10
00868	renala transplant (recipient)	10
	(For donor nephrectomy, use 00862.)	
	(For harvesting kidney from brain-dead patient, use 01990.)	
00870	cystolithotomy	5
00872	Anesthesia for lithotrypsy, extracorporeal shock wave.	7
00880	Anesthesia for procedures on major lower abdominal vessels; not otherwise specified.	15
00882	inferior vena cava ligation	10
00884	transvenous umbrella insertion.	5
	PERINEUM	
00900	Anesthesia for procedures on perineal integumentary system (including biopsy of male genital system); not otherwise specified.	3
00902	anorectal procedure (including endoscopy and/or biopsy).	4
00904	radical perineal procedure	7
00906	vulvectomy	4
00908	perineal prostatectomy	6
00910	Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified.	3
00912	transurethral resection of bladder tumor(s).	5
00914	transurethral resection of prostate.	5
00916	post-transurethral resection bleeding.	5
00920	Anesthesia for procedures on male external genitalia; not otherwise specified.	3
00922	seminal vesicles	6
00924	undescended testis, unilateral or bilateral.	4
00926	radical orchiectomy, inguinal.	4
00928	radical orchiectomy, abdominal.	6
00930	orchiopexy, unilateral and bilateral.	4
00932	complete amputation of penis.	4
00934	radical amputation of penis with bilateral inguinal lymphadenectomy.	6

APPENDIX—UNIFORM RELATIVE VALUE GUIDE—Continued

CPT-4	Procedure	Base units
00936	radical amputation of penis with bilateral inguinal and iliac lymphadenectomy.	8
00938	insertion of penile prosthesis (perineal approach).	4
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified.	3
00942	colpotomy, colpectomy, colporrhaphy.	4
00944	vaginal hysterectomy	6
00946	vaginal delivery	5
00948	cervical cerclage	4
00950	culdoscopy	5
00952	hysteroscopy	4
00955	Continuous epidural analgesia, for labor and vaginal delivery.	5
	PELVIS (EXCEPT HIP)	
01000	Anesthesia for procedures on anterior integumentary system of pelvis (anterior to iliac crest), except external genitalia.	3
01110	Anesthesia for procedures on posterior integumentary sysem of pelvis (posterior to iliac crest), except perineum.	5
01120	Anesthesia for procedures on bony pelvis.	6
01130	Anesthesia for body cast application or revision.	3
01140	Anesthesia for interpelviabdominal (hind quarter) amputation.	15
01150	Anesthesia for radical procedures for tumor of pelvis, except hind quarter amputation.	8
01160	Anesthesia for closed procedures involving symphysis pubis or sacroiliac joint.	4
01170	Anesthesia for open procedures involving symphysis pubis or sacroiliac joint.	8
01180	Anesthesia for obturator neurectomy; extrapelvic.	3
01190	intrapelvic	4
	UPPER LEG (EXCEPT KNEE)	
01200	Anesthesia for all closed procedures involving hip joint.	4
01202	Anesthesia for arthroscopic procedures of hip joint.	4
01210	Anesthesia for open procedures involving hip joint; not otherwise specified.	6
01212	hip disarticulation	10
01214	total hip replacement or revision.	10
01220	Anesthesia for all closed procedures involving upper ⅔ of femur.	4
01230	Anesthesia for open procedures involving upper ⅔ of femur; not otherwise specified.	6
01232	amputation	5
01234	radical resection	8
01240	Anesthesia for all procedures on integumentary system of upper leg.	3
01250	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of upper leg.	4
01260	Anesthesia for all procedures involving veins of upper leg, including exploration.	3
1270	Anesthesia for procedures involving arteries of upper leg, including bypass graft; not otherwise specified.	8
01272	femoral artery ligation	4
01274	femoral artery embolectomy.	6
	KNEE AND POPLITEAL AREA	
01300	Anesthesia for all procedures on integumentary system of knee and/or popliteal area.	3
01320	Anesthesia for all procedures on nerves, muscles, tendons, fascia and bursae of knee and/or popliteal area.	4
01340	Anesthesia for all closed procedures on lower ⅓ of femur.	4
01360	Anesthesia for all open procedures on lower ⅓ of femur.	5
01380	Anesthesia for all closed procedures on knee joint.	3
01382	Anesthesia for arthroscopic procedures of knee joint.	3
01390	Anesthesia for all closed procedures on upper ends of tibia and fibula, and/or patella.	3
01392	Anesthesia for all open procedures on upper ends of tibia and fibula and/or patella.	4
01400	Anesthesia for open procedures on knee joint; not otherwise specified.	4
01402	total knee replacement	7
01404	disarticulation at knee	5
01420	Anesthesia for all cast applications, removal, or repair involving knee joint.	3
01430	Anesthesia for procedures on veins of knee and popliteal area; not otherwise specified.	3
01432	arteriovenous fistula	5
01440	Anesthesia for procedures on arteries of knee and popliteal area; not otherwise specified.	5
01442	popliteal thromboendarterectomy, with or without patch graft.	8
01444	popliteal excision and graft or repair for occlusion or aneurysm.	8
	LOWER LEG (BELOW KNEE)	
	(Includes ankle and foot)	
01460	Anesthesia for all procedures on integumentary system of lower leg, ankle, and foot.	3
01462	Anesthesia for all closed procedures on lower leg, ankle, and foot.	3
01464	Anesthesia for arthroscopic procedures of ankle joint.	3
01470	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; not otherwise specified.	3
01472	repair of ruptured Achilles tendon, with or without graft.	5
01474	gastrocnemius recession (e.g., Strayer procedure).	5
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified.	3
01482	radical resection	4
01484	osteotomy or osteoplasty of tibia and/or fibula.	4
01486	total ankle replacement	7
01490	Anesthesia for lower leg cast application, removal, or repair.	3
01500	Anesthesia for procedures on arteries of lower leg, including bypass graft; not otherwise specified.	8
01502	embolectomy, direct or catheter.	6
01520	Anesthesia for procedures on veins of lower leg; not otherwise specified.	3
01522	venous thrombectomy, direct or catheter.	5
	SHOULDER AND AXILLA	
	(includes humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint)	
01600	Anesthesia for all procedures on integumentary system of should and axilla.	3
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla.	5
01620	Anesthesia for all closed procedures on humeral head and neck, sternoclavicular joint, and shoulder joint.	4
01622	Anesthesia for arthroscopic procedures of shoulder joint.	4
01630	Anesthesia for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified.	5
01632	radical resection	6
01634	shoulder disarticulation	9
01636	interthoracoscapular (forequarter) amputation.	15
01638	total should replacement	10
01650	Anesthesia for procedures on arteries of shoulder and axilla; not otherwise specified.	6
01652	axillary-brachial aneurysm	10
01654	bypass graft	8
01656	axillary-femoral bypass graft.	10
01670	Anesthesia for all procedures on veins of shoulder and axilla.	4
01680	Anesthesia for shoulder cast application, removal or repair; not otherwise specified.	3
10682	shoulder spica	4
	UPPER ARM AND ELBOW	
01700	Anesthesia for all procedures on integumentary system of upper arm and elbow.	3
01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, bursae of upper arm and elbow; not otherwise specified.	3
01712	tenotomy, elbow to shoulder, open.	5

APPENDIX—UNIFORM RELATIVE VALUE GUIDE—Continued

CPT-4	Procedure	Base units
01714	tenoplasty, elbow to shoulder.	5
01716	tenodesis, rupture of long tendon of biceps.	5
01730	Anesthesia for all closed procedures on humerus and elbow.	3
01732	Anesthesia for arthroscopic procedures of elbow joint.	3
01740	Anesthesia for open procedures on humerus and elbow; not otherwise specified.	4
01742	osteotomy of humerus	5
01744	repair of nonunion or malunion of humerus.	5
01756	radical procedures	6
01758	excision of cyst or tumor of humerus.	5
01760	total elbow replacement	7
01770	Anesthesia for procedures on arteries of upper arm; not otherwise specified.	8
01772	embolectomy	6
01780	Anesthesia for procedures on veins of upper arm and elbow; not otherwise specified.	3
01782	phleborrhaphy	4
	FOREARM, WRIST AND HAND	
01800	Anesthesia for all procedures on integumentary system of forearm, wrist and hand.	3
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, bursae of forearm, wrist, and hand.	3
01820	Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones.	3
01830	Anesthesia for open procedures on radius, ulna, wrist, or hand bones; not otherwise specified.	3
01832	total wrist replacement	6
01840	Anesthesia for procedures on arteries of forearm, wrist, and hand; not otherwise specified.	6
01842	embolectomy	6
01844	Anesthesia for vascular shunt, or shunt revision, any type (e.g., dialysis).	6
01850	Anesthesia for procedures on veins of forearm, wrist, and hand; not otherwise specified.	3
01852	phleborrhaphy	4
01860	Anesthesia for forearm, wrist, or hand cast application, removal or repair.	3
	RADIOLOGICAL PROCEDURES	
01900	Anesthesia for injection procedure for hysterosalpingography.	3
01902	Anesthesia for burr hole(s) for ventriculography.	9
01904	Anesthesia for injection procedure for pneumoencephalography.	7
01906	Anesthesia for injection procedure for myelography; lumbar.	5
01908	cervical	5
01910	posterior fossa	9
01912	Anesthesia for injection procedure for discography; lumbar.	5
01914	cervical	6
01916	Anesthesia for arteriograms, needle; carotid, or vertebral.	5

APPENDIX—UNIFORM RELATIVE VALUE GUIDE—Continued

CPT-4	Procedure	Base units
01918	retrograde, brachial or femoral.	5
01920	Anesthesia for cardiac catheterization including coronary arteriography and ventriculography (not to include Swan-Ganz catheter).	7
01921	Anesthesia for angioplasty	7
01922	Anesthesia for computerized axial tomography scanning or magnetic resonance imaging.	7
	MISCELLANEOUS PROCEDURE(S)	
01990	Physiological support for harvesting of organ(s) from brain-dead patient.	7
01995	Regional IV administration of local anesthetic agent (upper or lower extremity).	5
01996	Daily management of epidural or subarachnoid drug administration.	3
01999	Unlisted anesthesia procedure(s).	*I.C.
Q0045	Anesthesia for iridectomy	4
Q0047	Anesthesia for blepharoplasty	4

* Individual Consideration.

[FR Doc. 90-18327 Filed 8-6-90; 8:45 am]

BILLING CODE 4120-03-M

42 CFR Parts 412 and 413

[BPD-672-CN]

RIN 0938-AE73

Medicare Program, Fiscal Year 1990; Mid-Year Changes to the Inpatient Hospital Prospective Payment System; Correction

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Correction of final rule.

SUMMARY: This document corrects technical errors to the final rule published in the April 20, 1990 issue of the **Federal Register** (FR Doc. 90-9208), beginning on page 15150.

FOR FURTHER INFORMATION CONTACT: Barbara Wynn, (301) 966-4529.

SUPPLEMENTARY INFORMATION: We are making the following corrections to the April 20, 1990 document:

1. On page 15151, in the second column, in the seventh line from the top, the word "date" is corrected to read "data".

2. On page 15154, in the first column, beginning with the third line from the top the clause "If the hospital's disproportionate patient percentage is less than 20.2 percent," is corrected to read "If the hospital's disproportionate patient percentage is equal to or less than 20.2 percent.".

§ 412.106 [Corrected]

3. On page 15174, in the third column, in § 412.106(d)(2)(i)(B), the clause "If the hospital's disproportionate patient percentage is less than 20.2 percent," is corrected to read "If the hospital's disproportionate patient percentage is equal to or less than 20.2 percent,".

§ 412.108 [Corrected]

4. On page 15175, in the third column in § 412.108, the designation of the second paragraph (d)(3)(i) is corrected to read (d)(3)(ii); and the designation of paragraph (d)(3)(ii) is corrected to read (d)(3)(iii).

5. On page 15179, in Table 2b, in the fifth line of the table, the wage index value for Lenawee, MI is corrected by changing "1.1580" to "1.0242".

6. On page 15179, in Table 2c, in the eighth line of the table, the wage index value for Morrow, OH is corrected by changing "0.8568" to "0.8650".

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare-Hospital Insurance)

Dated: August 1, 1990.

Neil J. Stillman,

Deputy Assistant Secretary for Information Resources Management.

[FR Doc. 90-18420 Filed 8-6-90; 8:45 am]

BILLING CODE 4120-01-M

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

RIN 1018-AB31

Endangered and Threatened Wildlife and Plants; Determination of Threatened Status for the Puritan Tiger Beetle and the Northeastern Beach Tiger Beetle

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Final rule.

SUMMARY: The service determines threatened status for the Puritan tiger beetle (*Cicindela puritana*) and for the northeastern beach tiger beetle (*Cicindela dorsalis dorsalis*), two beach-dwelling beetles of the family Cicindelidae. Critical habitat is not being designated. The Puritan tiger beetle was known historically from numerous sites along the Connecticut River in Vermont, New Hampshire, Massachusetts and Connecticut, and from along the Chesapeake Bay in