By direction of the Secretary.

Donald L. Neilson,

Director, Records Management Service.

New Collection

1. VA Transitional House Loan Program
   a. VA Form 10–0146, Loan Application Transitional Housing for Veterans of Substance Abuse
   b. VA Form 10–0146A, Installment Loan Agreement
   c. VA Form 10–0146B, Request for Verification of Deposit
   d. VA Form 10–0146C, Incorporated Organization Borrowing Resolution
   e. VA Form 10–0146D, Loan Agreement
   f. VA Form 10–0146E, Applicant's History, Experience and Plans
2. Under the Transitional House Loan Program, VA will make loans to non-profit organizations to assist in the provision of transitional housing for veterans who are in recovery for the treatment of substance abuse. The forms constitute the applicant's agreement to the terms of the loan and repayment provision.
3. Non-profit institutions
4. 326 hour
5. Estimated Average burden hours per respondent 1 hour 33 minutes
   a. VA Form 10–0146—40 minutes
   b. VA Form 10–0146A—1 minute
   c. VA Form 10–0146B—20 minutes
   d. VA Form 10–0146C—1 minute
   e. VA Form 10–0146D—1 minute
   f. VA Form 10–0146E—9 hours 30 minutes
6. One-time
7. 210 respondents

[FR Doc. 94–15353 Filed 6–23–94; 8:45 am]

BILLING CODE 8320–01–M

Sunshine Act Meetings

Federal Register
Vol. 59, No. 121
Friday, June 24, 1994

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

FEDERAL DEPOSIT INSURANCE CORPORATION

Notice of Agency Meeting

Pursuant to the provisions of the "Government Sunshine Act" (5 U.S.C. 552b), notice is hereby given that at 10:00 a.m. on Tuesday, June 21, 1994, the Board of Directors of the Federal Deposit Insurance Corporation met in closed session to consider matters relating to the Corporation's corporate and supervisory activities.

In calling the meeting, the Board determined, on motion of Acting Chairman Andrew C. Hove, Jr., seconded by Director Jonathan L. Fiechter (Acting Director, Office of Thrift Supervision), concurred in by Ms. Judith A. Walter, acting in the place and stead of Director Eugene A. Ludwig (Comptroller of the Currency), that Corporation business required its consideration of the matters on less than seven days' notice to the public; that no earlier notice of the meeting was practicable; that the public interest did not require consideration of the matters in a meeting open to public observation; and that the matters could be considered in a closed meeting by authority of subsections (c)(4), (c)(6), (c)(8), (c)(9)(A)(ii), (c)(9)(B), and (c)(10) of the "Government in the Sunshine Act" (5 U.S.C. 552b (c)(4), (c)(6), (c)(8), (c)(9)(A)(ii), (c)(9)(B), and (c)(10)).

The meeting was held in the Board Room of the FDIC Building located at 550—17th Street, NW., Washington, DC.

Dated: June 21, 1994.

Federal Deposit Insurance Corporation.

Leneta G. Gregorie,

Acting Assistant Executive Secretary.

[FR Doc. 94-15471 Filed 6-22-94; 8:59 am]

BILLING CODE 6714-01-M

BLACKSTONE RIVER VALLEY NATIONAL HERITAGE CORRIDOR

Notice of Public Meeting

The Blackstone River Valley National Heritage Corridor Commission will Hold a Public Meeting to solicit comments on the proposed Boundary expansion of the Blackstone River Valley National Heritage Corridor.

Notice is hereby given in accordance with Section 552b of Title 5, United States Code, that this meeting will be held. The Commission was established pursuant to Public Law 99-647, in order to establish a management framework to protect, enhance and interpret the nationally significant resources in the Blackstone Valley.

The meeting will be held at Worcester City Hall, 455 Main Street, Worcester, MA. It will be in the Council Chambers at 7:00 PM on Monday, July 11, 1994.

The Public is invited to discuss the boundary expansion at the meeting and/or provide written comments at that time.

James R. Pepper,

Executive Director, Blackstone River Valley National Heritage Corridor.

[FR Doc. 94-15542 Filed 6-22-94; 2:46 pm]

BILLING CODE 4310-70-P

BLACKSTONE RIVER VALLEY NATIONAL HERITAGE CORRIDOR

Notice of Public Meeting

The Blackstone River Valley National Heritage Corridor Commission will Hold a Public Meeting to solicit comments on the proposed Boundary expansion of the Blackstone River Valley National Heritage Corridor.

Notice is hereby given in accordance with Section 552b of Title 5, United States Code, that this meeting will be held. The Commission was established pursuant to Public Law 99-647, in order to establish a management framework to protect, enhance and interpret the nationally significant resources in the Blackstone Valley.

The meeting will be held at Smithfield Town Hall, Smithfield, RI. It will be at 7:00 PM on Thursday, July 14, 1994.

The Public is invited to discuss the boundary expansion at the meeting and/or provide written comments at that time.

James R. Pepper,

Executive Director, Blackstone River Valley National Heritage Corridor.

[FR Doc. 94-15543 Filed 6-22-94; 2:46 pm]

BILLING CODE 4310-70-P

SECURITIES AND EXCHANGE COMMISSION

Agency Meeting

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Pub. L. 94-409, that the Securities and Exchange Commission will hold the following meeting during the week of June 27, 1994.

A closed meeting will be held on Tuesday, June 28, 1994, at 10:00 a.m.

Commissioners, Counsel to the Commissioners, the Secretary to the Commission, and recording secretaries will attend the closed meeting. Certain staff members who have an interest in the matters may also be present.

The General Counsel of the Commission, or his designee, has certified that, in his opinion, one or more of the exemptions set forth in 5 U.S.C. 552b(c) (4), (8), (9)(A) and (10) and 17 CFR 200.402(a) (4), (8), (9)(i) and (10), permit consideration of the scheduled matters at a closed meeting.

Commissioner Beese, as duty officer, voted to consider the items listed for the closed meeting in a closed session.

The subject matter of the closed meeting scheduled for Tuesday, June 28, 1994, at 10:00 a.m., will be:

Institution of injunctive actions.

Institution of administrative proceedings of an enforcement nature.

Settlement of injunctive actions.

Settlement of administrative proceedings of an enforcement nature.

At times, changes in Commission priorities require alterations in the scheduling of meeting items. For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact: Bruce Rosenblum, (202) 942-0500.

Dated: June 22, 1994.

Johathan G. Katz,

Secretary.

[FR Doc. 94-15554 Filed 6-22-94; 3:45 pm]

BILLING CODE 8010-01-M

Corrections

Federal Register
Vol. 59, No. 121
Friday, June 24, 1994

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

ARCHITECTURAL AND TRANSPORTATION BARRIERS COMPLIANCE BOARD

36 CFR Part 1191

[Docket No. 92-2]

RIN 3014 AA12

Americans with Disabilities Act (ADA) Accessibility Guidelines for Buildings and Facilities; State and Local Government Facilities

Correction

In rule document 94-14304 beginning on page 31676, in the issue of Monday, June 20, 1994, make the following correction.

On page 31676, in the first column, under *Comment date:* in the last line, "December 20, 1994." should read "August 19, 1994."

BILLING CODE 1505-01-D, 1994 / Corrections

federal register

Friday
June 24, 1994

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 410 and 414

Medicare Program; Refinements to Geographic Adjustment Factor Values and Other Policies Under the Physician Fee Schedule; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410 and 414

[BPD–789–P]

RIN 0938–AG52

Medicare Program; Refinements to Geographic Adjustment Factor Values and Other Policies Under the Physician Fee Schedule

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

ACTION: Proposed rule.

SUMMARY: This proposed rule discusses changes to the geographic adjustment factor values and fee schedule payment areas, proposed relative value units for certain physician services, revisions to payment policies for specific physician services, and a change to the Medicare Volume Performance Standard. This proposed rule also discusses implementation of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66) provision regarding payment for antigens. This provision places antigens under the physician fee schedule and subjects them to charge limits. This proposed rule solicits public comments on the proposed changes.

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on August 23, 1994.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD–789–P, P.O. Box 7519, Baltimore, MD 21207–0519.

If you prefer, you may deliver your written comments to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, MD 21207.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPD–789–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 783–3238 or by faxing to (202) 512–2250. The cost for each copy is $6. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: For further information concerning the proposed refinements to the geographic adjustment factor values and changes to the geographic practice cost indices and payment areas, contact Bob Ulikowski of the Health Care Financing Administration, (410) 966–5721. For issues related to the proposed relative value units for certain physician services and payment policies for specific physician services and supplies, contact Elizabeth Holland of the Health Care Financing Administration, (410) 966–1309.

SUPPLEMENTARY INFORMATION: To assist readers in referencing sections contained in this proposed rule, we are providing the following table of contents:

Table of Contents

I. Background
A. Legislative History
B. Recent **Federal Register** Publications
II. Specific Proposals for CY 1995
A. GPCI Changes
1. Development of the GPCIs
2. Proposed Revised GPCIs
a. Work GPCIs
b. Practice Expense GPCIs
c. Malpractice GPCIs
3. Impact of Revised GPCIs
B. Payment Area (Locality) Changes
C. Work RVUs—RVUs for Carrier-Priced and Non-Medicare CPT Codes
1. Methodology (Includes Table 1—AMA RUC Recommendations and HCFA's Proposed RVUs)
2. RUC Recommendations That Were Not Accepted
a. Reconstructive and Cosmetic Plastic Surgery
b. Maxillofacial Surgery (CPT Codes 21137 through 21139 and 21181)
c. Respiratory System—Laryngoplasty (CPT Code 31582) for Laryngeal Stenosis, with Graft or Core Mold, Including Tracheotomy
d. Vascular—Penile Revascularization (CPT Code 37788), Artery with or without Vein Graft
e. Vestibuloplasty (CPT Codes 40840 through 40845)
f. Urology
g. Ophthalmology
h. Newborn Care
3. Comment Process for Proposed RVUs
4. Establishment of Practice Expense and Malpractice Expense RVUs
D. Separate Payment for Physician Care Plan Oversight Services
1. Background
2. Physicians Eligible To Receive Payment
3. Level of Payment
4. Budget Neutrality
5. Conditions for Payment
E. Payment for Multiple Surgical Procedures
F. Application of Site-of-Service Payment Differential
G. Bundled Services
1. Generation and Interpretation of Automated Data (CPT Codes 78890 and 78891)
2. Noninvasive Ear or Pulse Oximetry (CPT Code 94760)
H. RVUs for Doppler Echocardiography (CPT Code 93325)
I. Nuclear Medicine
J. End-Stage Renal Disease (ESRD)
1. Hospital Inpatient Dialysis on the Same Day as an Evaluation and Management Service
2. Payment for Outpatient ESRD-Related Services under the Physician Fee Schedule
a. Development of the Monthly Capitation Payment (MCP)
b. Proposed Inclusion of the MCP under the Physician Fee Schedule
K. Services Considered to Be Medicare Part A Services
III. Implementation of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66)—Payment for Antigens (Allergen Immunotherapy)
A. Background and Legislative Change
B. CPT and HCPCS Codes
C. Proposed RVUs
D. Budget Neutrality
E. Transition
IV. Change in the MVPS Calculation for FY 1996
V. Changes to the Regulations
VI. Collection of Information Requirements
VII. Response to Comments
VIII. Regulatory Impact Analysis
A. Regulatory Flexibility Act
B. Effects of Implementing Proposed Policy Changes to GPCIs
C. Payment Area (Locality) Changes
D. Effects of Proposed Work RVUs for Carrier-Priced and Non-Medicare CPT Codes
E. Effects of Proposed Payment Policy Revisions
1. Separate Payment for Physician Care Plan Oversight Services
2. Payment for Multiple Surgical Procedures
3. Application of Site-of-Service Payment Differential

4. Bundled Services
a. Generation and Interpretation of Automated Data (CPT Codes 78890 and 78891)
b. Noninvasive Ear or Pulse Oximetry (CPT Code 94760)
5. RVUs for Doppler Echocardiography (CPT Code 93325)
6. Nuclear Medicine
7. ESRD—Hospital Inpatient Dialysis on the Same Day as an Evaluation and Management Service
8. Services Considered to be Medicare Part A Services
F. Effects of Payment for Antigens (Allergen Immunotherapy)
G. Change in the MVPS Calculation for FY 1996
H. Rural Hospital Impact Statement

Text of Proposed Regulations

Addenda

Addendum A—1994 Geographic Practice Cost Indices by Medicare Carrier and Locality
Addendum B—1996 Geographic Practice Cost Indices by Medicare Carrier and Locality
Addendum C—1995 Geographic Practice Cost Indices by Medicare Carrier and Locality
Addendum D—Changes in Geographic Adjustment Factor 1996 vs. 1994
Addendum E—1996 Geographic Practice Cost Indices and Geographic Adjustment Factors for States with Multiple Localities
Addendum F—1995 Geographic Practice Cost Indices and Geographic Adjustment Factors for States with Multiple Localities
Addendum G—Reference Set with 1994 Work RVUs
Addendum H—Procedure Codes Subject to the Site-of-Service Differential

In addition, because of the many organizations and terms to which we refer by acronym in this final rule, we are listing those acronyms and their corresponding terms in alphabetical order below:

AMA—American Medical Association
ASC—Ambulatory surgical center
CF—Conversion factor
CFR—Code of Federal Regulations
CHER—Center for Health Economics Research
CMD—Carrier medical director
CMSA—Consolidated Metropolitan Statistical Area
CPT—[Physicians'] Current Procedural Terminology (4th Edition, 1994, copyrighted by the American Medical Association)
CRNA—Certified registered nurse anesthetist
CY—Calendar year
ESRD—End-Stage Renal Disease
FMR—Fair market rental
FY—Fiscal year
GAF—Geographic adjustment factor
GAO—General Accounting Office
GPCI—Geographic practice cost index
HCFA—Health Care Financing Administration
HCPCS—HCFA Common Procedure Coding System
HHA—Home health agency
HHS—[Department of] Health and Human Services
HUD—[Department of] Housing and Urban Development
JCAI—Joint Council of Allergy and Immunology
MCP—Monthly capitation payment
MEI—Medicare Economic Index
MSA—Metropolitan Statistical Area
MVPS—Medicare volume performance standards
NF—Nursing facility
NTIS—National Technical Information Service
OBRA—Omnibus Budget Reconciliation Act
PC—Professional component
RFA—Regulatory Flexibility Act
RUC—[AMA Specialty Society] Relative [Value] Update Committee
RVU—Relative value unit
SNF—Skilled Nursing Facility
TC—Technical component
UI—Urban Institute

I. Background

A. Legislative History

The Medicare program was established in 1965 by the addition of title XVIII to the Social Security Act (the Act). Until January 1, 1992, Medicare paid for physicians' services based on a reasonable charge system. This system led to payment variations among types of services, physician specialties, and geographic areas. Thus, the Congress included a physician payment reform provision in the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Public Law 101–239, enacted on December 19, 1989.

Section 6102 of OBRA '89 amended title XVIII of the Act by adding a new section 1848, "Payment for Physicians' Services." This section contains three major elements:

(1) A fee schedule for the payment of physicians' services;

(2) A Medicare volume performance standard (MVPS) for the rates of increase in Medicare expenditures for physicians' services; and

(3) Limits on the amounts that nonparticipating physicians can charge beneficiaries. The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) based on the resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense, and malpractice. The Omnibus Budget Reconciliation Acts of 1990 (OBRA '90) and 1993 (OBRA '93), Public Laws 101–508 and 103–66, enacted on November 5, 1990, and August 10, 1993, respectively, contained several modifications and clarifications to the OBRA '89 provisions that established the physician fee schedule.

Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, adjust the geographic practice cost indices (GPCIs) at least every 3 years. This section also requires us to phase in the adjustment over 2 years and implement only one-half of any adjustment if more than 1 year has elapsed since the last GPCI revision. The GPCIs were first implemented in 1992 and have not been reviewed since that time. Thus, we are required to complete the first GPCI review and implement only one-half of any adjustment by 1995 and one-half in 1996.

The Act requires that payments vary among fee schedule areas according to geographic indices. In general, the fee schedule areas that existed under the prior reasonable charge system were retained under the fee schedule. A detailed discussion of fee schedule areas can be found in the June 5, 1991 proposed rule (56 FR 25832) and in the November 25, 1991 final rule (56 FR 59514). We are required by section 1848(e)(1)(A) of the Act to develop separate indices to measure relative cost differences among fee schedule areas compared to the national average for each of the three fee schedule components. While requiring that the practice expense GPCIs and malpractice GPCIs reflect the full relative cost differences, the Act requires that the work indices reflect only one-quarter of the relative cost differences compared to the national average.

B. Recent Federal Register Publications

We published a final rule on November 25, 1991, (56 FR 59502) to implement section 1848 of the Act by establishing a fee schedule for physicians' services furnished on or after January 1, 1992. In the November 1991 final rule (56 FR 59511), we stated our intention to update RVUs for new and revised codes in the American Medical Association's (AMA) Physicians' Current Procedural Terminology (CPT) through an "interim RVU" process every year. Our first update to the RVUs was published on November 25, 1992, as a final notice with a 60-day comment period on new and revised RVUs only (57 FR 55914).

On July 14, 1993, we published a proposed rule (58 FR 37994) to announce our intention to revise the refinement process used to establish physician work RVUs and to revise payment policies for specific physician services and supplies. On December 2, 1993, we published a final rule (58 FR 63626) announcing revised payment policies and RVUs for 1994 (we solicited comments on new and revised RVUs).

II. Specific Proposals for Calendar Year (CY) 1995

A. GPCI Changes

1. Development of the GPCIs

The GPCIs were developed by a joint effort of the Urban Institute (UI) and the Center for Health Economics Research (CHER) under contract to HCFA. Indices were developed that measured the relative cost differences among areas compared to the national average in a market basket of goods. In this case, the market basket consists of the resources used in operating a private medical practice. The resource inputs are: physician work or net income; employee wages; office rent; medical equipment, supplies, and other miscellaneous expenses; and malpractice insurance. Employee wages, rents, and miscellaneous expenses are combined to comprise the practice expense component of the GPCIs. The weights of these components in the current and the proposed revised GPCIs are as follows:

Input component	Percentage of practice expense	
	Current GPCI	Revised GPCI
Physician Work	54.2	54.2
Practice Expense	40.2	41.0
Employee Wages	15.7	16.3
Rent	11.1	10.3
Miscellaneous Expenses	13.4	14.4
Malpractice	5.6	4.8
Total	100.0	100.0

The resource inputs and their weights were obtained from the AMA's Socioeconomic Characteristics of Medical Practice. The weights for the current GPCIs are from the AMA's 1987 survey, while the weights for the revised GPCIs are from the AMA's 1989 survey. The 1987 weights were the latest available when the current GPCIs were being developed. The 1989 weights were used in revising the Medicare Economic Index (MEI) discussed in the November 1992 final rule (57 FR 55899). The MEI is a measure of annual increases in the cost of operating a private medical practice and is used in the annual update of the fee schedule conversion factor (CF). Since the GPCIs and the MEI use the same resource inputs to measure practice expenses—the GPCIs measure relative costs among areas while the MEI measures the national annual rate of increase in costs—we believe the same weights should be used.

Once the components and their weights were determined, data sources had to be found that were widely and consistently available in all fee schedule areas to measure costs. After examining many sources, the following proxies were selected as the best available sources for measuring each component of the current GPCIs:

- Physician work—The median hourly earnings, based on a 20-percent sample of 1980 census data, of workers in six professional specialty occupation categories (engineers, surveyors, and architects; natural scientists and mathematicians; teachers, counselors, and librarians; social scientists, social workers, and lawyers; registered nurses and pharmacists; writers, artists, and editors) with 5 or more years of college. Adjustments were made to produce a standard occupational mix in each area. The actual reported earnings of physicians were not used to adjust geographical differences in fees because these fees are, in large part, the determinants of the earnings. We believe that the earnings of physicians will vary among areas to the same degree that the earnings of other professionals vary.
- Employee wages—Median hourly wages of clerical workers, registered nurses, licensed practical nurses, and health technicians were also based on a 20-percent sample of 1980 census data.
- Office rents—Residential apartment rental data produced annually by the Department of Housing and Urban Development (HUD) were used because there were insufficient data on commercial rents across all fee schedule areas.
- Medical equipment, supplies, and other miscellaneous expenses—UI and CHER assumed that this component is represented by a national market and that costs do not vary appreciably among areas. This component's index is 1.000 for all areas to indicate no variation from the national average.
- Malpractice—Premiums in 1985 and 1986 for a mature "claims made" policy (a policy that covers malpractice claims during the covered period) providing $100,000/$300,000 of coverage were used. Adjustments were made to incorporate the costs of $1 million/$3 million coverage and mandatory patient compensation fund requirements. Premium data were collected for physicians in three risk classes: low-risk (general practitioners who do not do surgery), moderate risk (general surgeons), and high-risk (orthopedic surgeons).

The areas selected for measurement purposes were the Metropolitan Statistical Areas (MSAs). Non-MSA areas within a State were aggregated into one residual area. Using MSAs for measurement satisfied the criteria of (1) Homogeneity in resource input prices within the area, and (2) a large enough size so that market areas are self-contained to minimize border crossing; that is, physicians would not move their offices a few miles to secure higher payments and patients would tend to receive services within their area.

The law requires, however, that the GPCIs reflect cost differences among fee schedule areas. Section 1848(j)(2) of the Act defines a fee schedule payment area as a locality that existed under the prior reasonable charge system. These reasonable charge localities were established by Medicare carriers on the basis of their knowledge of physician charging patterns and have changed little since the inception of the program in 1965. There is little consistency among carriers in locality structure. Some States contain a single locality, while others contain as many as 32 localities. Localities are unique to Medicare and do not necessarily correspond directly to political boundaries (counties or cities), geographic areas, or to the MSA/non-MSA structure. It was thus necessary to map Medicare localities to the MSA and non-MSA aggregation of GPCI data. Where localities crossed MSA boundaries, MSA indices were converted to Medicare locality indices by population weights.

Detailed discussions of the methodology and data sources of the current GPCIs can be obtained by requesting the following studies from the National Technical Information Service (NTIS) by calling 1–800–553–NTIS, or (703) 487–4650 in Springfield, Virginia:

- The Urban Institute GPCI report "The Geographic Medicare Index: Alternative Approaches," NTIS PB89–216592.
- The supplement to "The Geographic Medicare Index: Alternative Approaches," NTIS PB91–113506. This interim version was published in the September 4, 1990 notice for the model fee schedule (55 FR 36238).
- The Urban Institute report "Refining the Malpractice Geographic Practice Cost Index," February 1991, NTIS PB91–155218. The related diskette is NTIS PB91–507491. This is the final version of the current GPCIs as published in the November 1991 final rule (56 FR 59785).

2. Proposed Revised GPCIs

The separate sections below on the revised GPCI components each contain a brief description of the differences in the current and the proposed revised GPCIs. The main criticism of the

existing GPCIs is that they are outdated because they are based on old data; for example, 1980 census data and 1985 and 1986 malpractice premiums, the most recent data available when the GPCIs were established. The revised GPCIs are based on the most current data available. As discussed in the brief descriptions of the revised indices, some minor changes from the current GPCI methodology were made in calculating some of the revised indices.

One methodological change was made that applied across all indices. As mentioned earlier, under the current GPCIs, where Medicare localities crossed MSA boundaries, MSA indices were converted to locality indices by population weights. Medicare expenditure weights were not used because the expenditures under the reasonable charge system contained large differences unrelated to relative cost differences among areas. In calculating the proposed revised GPCIs, where localities crossed MSA boundaries, locality indices were calculated by weights based on full fee schedule RVUs, which do reflect relative cost differences among areas. Full fee schedule RVUs were used rather than actual 1993 payments because some fee schedule payments are still affected by the transition and, thus, still reflect some reasonable charge payment levels and will continue to do so until the fee schedule transition period is over in 1996. The advantages of RVU weighting are that (1) The GPCIs will more closely reflect physician practice costs in the area where the services are furnished, whereas population weights reflect costs where the population lives, and (2) budget neutrality is preserved when combining multiple localities into larger areas, such as statewide localities.

a. *Work GPCIs.* Data from the 1990 20-percent sample of census data of median hourly earnings for the same six categories of professional specialty occupations as used in the current work GPCIs were used in calculating the revised work GPCIs. The current work GPCIs were calculated using 1980 census data of earnings for professionals with 5 or more years of college. That sample was no longer available in the 1990 census. The 1990 census educational classifications are by highest degree earned, rather than the 1980 census classification by years of schooling. Thus, it was not possible to obtain earnings exactly comparable to the 1980 data.

For 1990, data are available for all education and advanced degree samples, but not for 5 or more years of college. We elected to use the all education sample because its larger sample sizes make it more stable and accurate in less populous areas. Although it could be argued that physicians' earnings might more closely approximate the earnings of professionals with advanced degrees, the differences between the all education and advanced degree indices were negligible in all but a few of the smallest localities. We believe that the small sample size of advanced degree occupations in these small localities may produce inaccurate results.

The current work GPCIs utilize MSA-wide median wages for each county within an MSA. That is, all counties within an MSA are assigned the MSA-wide median wage even if there are wage variations within the MSA. We believe that this is appropriate for all but Consolidated Metropolitan Statistical Areas (CMSAs), the largest of the MSAs, such as New York. In these CMSAs, we replaced metropolitan-wide earnings with county-specific earnings. We believe that this change is appropriate because costs are, in fact, higher in central city areas (for example, Manhattan and San Francisco) than in the rest of the CMSA. County earnings better account for cost variations within these large metropolitan areas.

The work GPCIs reflect only one-fourth of the relative cost differences as required by law.

b. Practice expense GPCIs—(1) *Employee Wage Indices.* Data from the 1990 20-percent sample of census data of median hourly earnings for the same categories of medical and clerical occupations used in the current practice expense GPCIs were used in the revised practice expense GPCIs. These revised GPCIs use 1990 rather than 1980 census data. As with the work GPCIs, county level data were used for CMSAs to better reflect the cost variations within these large metropolitan areas.

(2) *Office Rent Indices.* As with the current practice expense GPCIs, HUD fair market rental (FMR) data for residential rents were again used as the proxy for physician office rents. The revised practice expense GPCIs reflect the final 1994 HUD FMRs. Like the work GPCIs and the employee wage index of the practice expense GPCIs, county level data were used in CMSAs to recognize the variations within the CMSA. This has the general effect of increasing the rent indices of Medicare localities comprised solely or primarily of central cities areas of CMSAs, for example, Manhattan and San Francisco.

The major criticism of the practice expense GPCIs rent index is that residential rather than commercial rent data were used. As mentioned earlier, for constructing the GPCIs we needed data that were widely and consistently available across all fee schedule areas. As with the current GPCIs, in revising the GPCIs, we again searched for private sources of commercial rent data that were widely and consistently available.

The private sources we found were not adequate. None of the sources contained data for nonmetropolitan areas, nor did any contain data for all metropolitan areas. The sources do not reflect the average commercial space in the area, but rather the particular type of space most relevant to the needs of the particular source's clients. In addition, the sample sizes were small. A comparison of the average rental for any particular city showed significant variation depending on the source. Also, we are not confident that the private commercial rent data that is available is representative of the type of office space used by physicians. In any case, the GPCIs measure relative differences among areas. We believe that commercial rents will generally vary among areas as residential rents vary.

No national data are readily available for physician office rent. Thus, some proxy must be used for this portion of the index. In addition, commercial rent data are not available for all areas from published statistical sources. We believe that the HUD FMR data remain the best available data for constructing the office rental index. They are available for all areas, are updated on an annual basis, and are consistent among areas and from year to year. Moreover, physicians frequently locate in areas and office space that are residential rather than commercial, for example, in apartment complexes and small strip commercial centers adjacent to residential areas. Residential rents may, in fact, be a better measure of the differences among areas in the physician office market than a general commercial rental index.

In any case, we are continuing to search for alternative sources of commercial rent data. We are currently analyzing rental data from the U.S. Postal Service, the General Services Administration, and the Internal Revenue Service. We are examining these data to assess their suitability for constructing rental indices.

(3) *Medical Equipment, Supplies, and Other Miscellaneous Expenses.* As mentioned earlier, the GPCIs assume that this component has a national market and that input prices do not vary among geographic areas. We were unable to find any data sources that demonstrated price differences by geographic area. Anecdotal and interview data with suppliers and manufacturers were inconclusive. While

some price differences may exist, they are more likely to be based on volume discounts rather than on geographic areas. Generally, it appears that manufacturers' prices do not vary among areas except for shipping costs. Since manufacturers and suppliers are located all over the country, shipping costs on the mainland do not vary significantly.

We did consider an add-on for shipping costs to Alaska, Hawaii, and Puerto Rico to recognize the added shipping distance. We decided against an add-on because there were no data to indicate how much the costs of shipping medical equipment and supplies to these areas increased their costs. We were able to ascertain that commercial shippers like United Parcel Service and Federal Express generally charge about 10 percent more to ship to Puerto Rico and about 20 percent more to ship to Alaska and Hawaii from the mainland. Medical equipment and supplies represent about 7 percent of physician practice costs. Even if shipping costs are 5 percent of the total equipment and supply costs, which we believe to be a high estimate, recognizing a 20-percent increase in shipping costs would increase payment levels by only 0.07 percent (.20 x .05 x .07 = .0007). The medical equipment, supplies, and miscellaneous expense index for all areas will continue to be 1.000 in the revised GPCIs.

c. *Malpractice GPCIs.* Malpractice premium data for a $1 million/$3 million mature "claims made" policy were collected and mandatory patient compensation funds were considered. However, more recent and comprehensive malpractice insurance data were used in calculating the revised malpractice GPCIs. The revised malpractice GPCIs are based on 1990 through 1992 premium data. Malpractice premiums are volatile and may change significantly from year to year. We decided to use the most recent 3-year average rather than the most recent single year to reduce the volatility and present a more accurate indication of malpractice premium trends over time.

We collected data on more specialties and from more insurers than were used to construct the current index. We collected data on 20 specialties, rather than on 3 as in the current malpractice GPCIs. The current malpractice GPCI data were largely drawn from a single nationwide insurer (St. Paul Fire and Marine) and were supplemented by several State-specific carriers in States in which St. Paul did not offer coverage. Subsequent analyses suggest that these data may no longer be representative of insurers operating in many States. For the revised malpractice GPCIs, data were collected from insurers that represent the great majority of the market in each State—about 82 percent on average with 60 percent as the lowest State market share. We believe that the more recent and comprehensive data greatly improve the accuracy of the malpractice GPCIs.

Detailed discussions of the technical aspects of the GPCIs including constructing a Laspereyes-type economic index, a discussion of other data sources that were examined and found to be inadequate and, therefore, not used, and many more detailed tables showing the differences among various alternatives for each of the GPCI studies can be obtained by requesting the following studies from NTIS by calling 1–800–553–NTIS, or (703) 487–4650 in Springfield, Virginia:

- "Updating the Geographic Practice Cost Index: Revised Cost Shares." Debra A. Dayhoff, John E. Schneider, and Gregory C. Pope. NTIS PB94–161072.
- "Updating the Geographic Practice Cost Index: The Physician Work GPCI." Gregory C. Pope and Debra A. Dayhoff. NTIS PB94–161080.
- "Updating the Geographic Practice Cost Index: The Practice Expense GPCI." Gregory C. Pope, Debra A. Dayhoff, Angella R. Merrill, and Killard W. Adamache. NTIS PB94–161098.
- "Updating the Geographic Practice Cost Index: The Malpractice GPCI." Stephen Zuckerman and Stephen Norton. NTIS PB94–161106.

3. Impact of Revised GPCIs

The proposed GPCIs would be implemented in a budget-neutral manner. They would not change the total national fee schedule payments that would have been made in 1995 had the current GPCIs been retained. The revised GPCIs will redistribute payments among fee schedule payment areas. The general geographic effects of this redistribution can be demonstrated by referring to Addenda A through F.

Fee schedule payments are the product of the RVUs, the GPCIs, and the CF. The current GPCIs were used in computing the original 1992 budget-neutral fee schedule CF. Updating the GPCIs changes the relative position of fee schedule areas compared to the national average. Since the changes represented by the proposed GPCIs could result in total payments either greater or less than what would have been paid if the GPCIs were not revised, it was necessary to rescale the proposed GPCIs to assure that their implementation is budget-neutral on a national basis. That is, the same total physician fee schedule payments would be made using the proposed GPCIs as would have been made were the current GPCIs retained.

We calculated that the proposed GPCIs would have resulted in slightly lower total national payments under the fee schedule. Since the law requires that each of the fee schedule component RVUs—work, practice expense, and malpractice—are separately adjusted by their respective GPCIs, we adjusted each of the GPCI components separately. To assure budget-neutrality, it was necessary to increase the proposed work GPCIs by 0.073 percent; to increase the practice expense GPCIs by 0.125 percent; and to increase the malpractice GPCIs by 2.307 percent. As all areas received the same percentage adjustments, the adjustments do not change the new relative positions among areas indicated by the proposed GPCIs.

Addendum A contains the current GPCIs. Addendum B contains the proposed fully revised GPCIs that would be effective in 1996. Addendum C contains the transition GPCIs for 1995, that is, one-half of the effect of the revised GPCIs, as required by section 1848(e)(1)(C) of the Act. For example, the current GPCIs for Birmingham, Alabama from Addendum A are: work, 0.981; practice expense, 0.913; and malpractice, 0.824. The revised 1996 GPCIs for Birmingham from Addendum B are: work, 0.994; practice expense, 0.912; and malpractice, 0.927. Thus, the proposed work GPCI for Birmingham represents an increase of about 1.3 percent, the revised practice expense GPCI represents a decrease of about 0.1 percent, and the revised malpractice GPCI represents an increase of about 12.5 percent. The 1995 transition GPCI changes shown in Addendum C would be about one-half of these amounts.

Because the three GPCI components have different weights, the overall effect of the changes cannot be estimated by summing the effects of the work, practice expense, and malpractice changes. For example, summing the changes would indicate an increase for Birmingham of 13.7 percent.

The overall effect of all three revised GPCI components on an area can be estimated by a comparison of area geographic adjustment factors (GAFs). The GAF for an area is the weighted composite of the three components. Using the revised practice cost weights in the table in section II.A.1, the current GAF for Birmingham is 0.946 ((.981×.542)+(.913×.410)+(.824×.048)). The revised GAF is 0.957. Thus, the overall effect of the revised GPCIs on Birmingham would be to generally

increase full fee schedule payments by about 1.2 percent. This is an estimate of the general overall effect on total payments across the entire Birmingham fee schedule area. Payment effects would vary for specific services as the component RVU weights for services vary from the GPCI component weights. (The closer the service component RVU weights are to the GPCI component weights, the closer the effect would be to the estimated GAF effect.) The effects on payments to individual physicians would vary depending on each physician's mix and volume of services. These are full fee schedule effects and do not reflect the 1992 through 1995 transition payment rules under which some payments are a blend of the fee schedule and the prior reasonable charge system.

To facilitate a comparison of the overall effect of the current and revised GPCIs, Addendum D contains a comparison of existing and revised fee schedule area GAFs in descending order of change. As this Addendum shows, no area GAF would increase by more than 7.8 percent or decrease by more than about 8.4 percent under the revised GPCIs. Thus, area full fee schedule payments would generally change by no more than about 8 percent under the revised GPCIs. Most areas would change by considerably less than this amount. About 75 percent of the areas would change by about 3 percent or less. Also, because of the 2-year transition, the effects in 1995 (the transition year) would be no more than one-half of the change indicated in Addendum D.

A comparison of the GAFs yields a more comprehensive comparison of the effects of the revised GPCIs than does a comparison of the changes in the individual GPCIs. For example, the work GPCIs for San Francisco, California would increase from 1.038 to 1.068, an increase of 2.9 percent. The malpractice GPCIs for San Francisco would decrease from 1.370 to 0.596, a decrease of 56.5 percent. However, as mentioned earlier, the work component would represent about 54 percent, and the malpractice component would represent about 5 percent of total resource costs. Thus, the 2.9-percent increase in the work GPCIs would generally increase payments by about 1.6 percent, while the 57-percent decrease in the malpractice GPCIs would generally decrease payments by about 2.8 percent, not 56.5 percent, in San Francisco. Overall, the San Francisco GAF would change from 1.163 to 1.153, a decrease of only about 0.9 percent.

Again we stress that the GPCIs measure relative cost differences among areas compared to the national average. The national average cost is represented by a value of about 1.000. (The value is not exactly 1.000 because of the budget neutrality rescaling discussed earlier.) A revised GPCI showing a decrease from the current value does not necessarily mean that absolute costs of an individual physician or absolute area costs have decreased. Instead, it means that costs in that area have decreased compared to national average costs. For example, a change in the malpractice GPCI from 0.990 to 0.950 does not necessarily mean that malpractice premiums for that area have decreased. Instead, it means that the more recent and comprehensive 1990 through 1992 malpractice data show that premiums in that area have decreased from 99 percent to 95 percent of the national average from the 1985 through 1986 premium data years.

We have included two additional informational tables in Addenda E and F. Addendum E contains 1996 revised statewide GPCIs and GAFs for States currently containing multiple payment areas. Addendum F contains 1995 transitional GPCIs and GAFs for these States. We are providing these tables so that States with multiple payment areas that are considering requesting a single statewide area can evaluate the effects of a change. These GPCIs are informational only and would have no effect unless a State changes to a single payment area.

B. Payment Area (Locality) Changes

As stated earlier, section 1848(j)(2) of the Act defines a physician fee schedule payment area as the locality existing under the reasonable charge system. This section did not, however, delete section 1842 of the Act, which gives us the authority to set localities. Thus, we believe that section 1848(j)(2) allows us to retain existing localities to facilitate changing to the physician fee schedule, but does not preclude us from making locality changes if warranted.

There is little consistency among carriers in locality structure. In the June 1991 proposed rule (56 FR 25832) and the November 1991 final rule (56 FR 59514) on the physician fee schedule, we stated that until we decide on ultimate large-scale changes, the only locality changes we would consider would be requests for converting individual States with multiple localities to a single statewide locality if "* * * overwhelming support from the physician community for the changes can be demonstrated." This willingness to consider applications from physicians in a State for conversion to a statewide locality, if overwhelming support on the part of winning and losing physicians has been demonstrated, reflects our belief that statewide localities generally are preferable to the present Medicare localities because they simplify program administration and encourage physicians to practice in rural areas by reducing urban/rural payment differentials.

We explained to States inquiring about conversions to a statewide payment area that these conversions involve taking a weighted average of the existing locality GPCIs to form a new statewide GPCI. This means that there may be "losing" (usually urban) areas, as well as "winning" (usually rural) areas within a State if a conversion is made. Overall, the change is budget neutral within the State. We further informed these States that a simple resolution passed by the State medical society is not sufficient proof of overwhelming support for the change among both rural and urban physicians. To assist States in deciding whether to convert to a statewide payment area, we published an informational list of projected statewide GPCIs in the June 1991 proposed rule (56 FR 25972). A slightly revised list of projected statewide GPCIs was published in the December 1993 final rule (58 FR 63638).

In most cases, States have been unable to generate the support of the losing physicians for the change. However, three States—Minnesota, Nebraska, and Oklahoma—were converted to statewide localities in 1992. (These conversions were announced in the November 1991 final rule (56 FR 59514).) Two additional States—North Carolina and Ohio—were converted to statewide localities in 1994. (These conversions were announced in the December 1993 final rule (58 FR 63638).)

We have since received formal petitions for statewide payment areas from Iowa and Pennsylvania. Only Iowa, however, presented evidence demonstrating sufficient support from "losing" areas to support the change. The Iowa Medical Society presented evidence that about 75 percent of its members, including about 70 percent of members in "losing" areas, support a statewide payment area. Therefore, we propose to convert Iowa to a statewide payment area effective January 1, 1995.

Section 1842 of the Act gives us the authority to set payment localities. We plan to review the existing payment locality structure for possible comprehensive changes in 1996. In the meantime, we will continue to consider statewide localities for those States in which physicians express a desire for a change. To ensure that the views of all physicians in an area are solicited and

not just the views of physicians who are members of the State medical societies, we will, of course, announce any proposed changes in the criteria for establishing localities or proposed changes to payment areas as part of the rulemaking process for the physician fee schedule.

C. Work RVUs—Carrier-Price and Non-Medicare CPT Codes

Several State Medicaid programs and commercial insurers have expressed interest in developing a resource-based fee schedule for physician services. To assist them, we are developing work RVUs for services not currently included in the Medicare physician fee schedule. These codes are currently noncovered, bundled, or carrier-priced under Medicare. We have no intention of changing our current payment policy regarding these services but, rather, wish to develop RVUs for these services to facilitate the adoption of the physician fee schedule by other payers.

1. Methodology (Includes Table 1—AMA RUC Recommendations and HCFA's Proposed RVUs)

As described in the November 1991 final rule on the 1993 fee schedule (56 FR 59511), we established a process, considering recommendations received from the AMA Relative Value Update Committee (RUC), for establishing interim RVUs for codes. RUC was formed in November 1991 and grew out of a series of discussions between the AMA and the major national medical specialty societies. RUC is comprised of 26 members; 22 are representatives of major specialty societies. The remaining members represent the AMA, the American Osteopathic Association, and the AMA's CPT Editorial Panel. The work of RUC is supported by an advisory committee made up of representatives of 65 specialty societies in the AMA House of Delegates. RUC uses a small group survey method to produce work RVUs that are voted on by RUC, with a two-thirds vote required for acceptance. RUC then submits to us those accepted RVUs as recommended values.

In December 1993, we received work RVU recommendations for approximately 90 codes from RUC. Physician panels consisting of carrier medical directors (CMDs) and HCFA staff reviewed the RUC recommendations by comparing them to other services on the fee schedule for which work RVUs had been established previously. The panels also considered the relationships among the codes for which we received RUC recommendations.

Work RVUs were not assigned to CPT code 54440 (plastic operation of penis for injury) for reasons discussed below. We propose allowing carriers to price this procedure. Also, we are not proposing RVUs for 18 preventive medicine procedures (CPT codes 99381 through 99404) for which we received RUC recommendations. We anticipate that these CPT codes will be revised and expect to receive new RUC recommendations for the revised codes. In addition, we received recommended RVUs for several transplant codes in December 1993. Since we were aware that RUC planned to address other transplant procedures in a subsequent meeting, we decided not to take action on the recommendations from the earlier meeting at this time. Instead, we plan to review the RUC RVUs for all transplant services during our refinement meeting scheduled for June 1994. Of the remaining CPT codes, based on the review described above by carrier medical directors and HCFA staff, we propose accepting the RUC recommendations for approximately 50 percent of the codes and propose decreasing the RUC recommendations for approximately 50 percent of the codes.

Table 1 is a listing of those codes for which we received recommended work RVUs. This table includes the following information:

- HCPCS (HCFA Common Procedure Coding System) code (Level 1 HCPCS code). This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC-recommended work RVUs. This column identifies the work RVUs recommended by RUC.
- HCFA proposed work RVUs. An asterisk identifies codes for which a discussion can be found in the narrative.

TABLE 1.—AMA RUC RECOMMENDATIONS AND HCFA'S PROPOSALS

HCPCS[1]	Description	RUC recommended work RVUs	HCFA proposed work RVUs
11950	Therapy for contour defects	1.23	[2]0.85
11951	Therapy for contour defects	1.73	[2]1.20
11952	Therapy for contour defects	2.47	[2]1.71
11954	Therapy for contour defects	2.71	[2]1.87
15775	Hair transport punch grafts	5.31	[2]4.00
15776	Hair transport punch grafts	7.44	[2]5.60
15850	Removal of sutures	0.79	0.79
19396	Design custom breast implant	2.96	[2]1.70
21137	Reduction of forehead	11.84	[2]9.50
21138	Reduction of forehead	14.81	[2]11.85
21139	Reduction of forehead	17.77	[2]14.22
21150	Reconstruct midface, lefort	24.68	24.68
21151	Reconstruct midface, lefort	27.64	27.64
21154	Reconstruct midface, lefort	29.61	29.61
21155	Reconstruct midface, lefort	33.56	33.56
21159	Reconstruct midface, lefort	41.45	41.45
21160	Reconstruct midface, lefort	45.40	45.40
21172	Reconstruct orbit/forehead	27.14	27.14
21175	Reconstruct orbit/forehead	32.57	32.57
21179	Reconstruct entire forehead	21.71	21.71
21180	Reconstruct entire forehead	24.68	24.68
21181	Contour cranial bone lesion	15.30	[2]9.50
21182	Reconstruct cranial bone	31.58	31.58
21183	Reconstruct cranial bone	34.55	34.55
21184	Reconstruct cranial bone	37.51	37.51

TABLE 1.—AMA RUC RECOMMENDATIONS AND HCFA'S PROPOSALS—Continued

HCPCS[1]	Description	RUC recommended work RVUs	HCFA proposed work RVUs
21188	Reconstruction of midface	21.71	21.71
30400	Reconstruction of nose	9.87	[2]8.85
30410	Reconstruction of nose	13.82	[2]9.95
30420	Reconstruction of nose	16.62	[2]12.76
30430	Revision of nose	7.40	[2]5.60
30435	Revision of nose	13.57	[2]9.65
31582	Revision of larynx	20.18	[2]16.32
31588	Revision of larynx	11.95	11.95
31590	Reinnervate larynx	6.43	6.43
31755	Repair of windpipe	14.85	14.85
36460	Transfusion service, fetal	6.66	6.66
37788	Revascularization, penis	22.70	[2]15.00
40840	Reconstruction of mouth	9.87	[2]8.40
40842	Reconstruction of mouth	9.87	[2]8.40
40843	Reconstruction of mouth	13.82	[2]11.76
40844	Reconstruction of mouth	18.26	[2]15.54
40845	Reconstruction of mouth	21.32	[2]18.14
50320	Removal of donor kidney	22.37	[2]16.16
54440	Repair of penis	11.84	[2]0.00
54670	Repair of testis injury	6.50	[2]5.33
55870	Electroejaculation	3.95	[2]0.30
61556	Incise skull/sutures	21.59	21.59
61557	Incise skull/sutures	21.71	21.71
61558	Excision of skull/sutures	24.68	24.68
61563	Excision of skull tumor	26.16	26.16
62115	Reduction of skull defect	20.73	20.73
62116	Reduction of skull defect	22.70	22.70
62117	Reduction of skull defect	25.66	25.66
62120	Repair skull cavity lesion	22.59	22.59
63700	Repair of spinal herniation	15.79	15.79
63702	Repair of spinal herniation	17.77	17.77
63704	Repair of spinal herniation	19.74	19.74
63706	Repair of spinal herniation	22.70	22.70
69300	Revise external ear	10.86	[2]5.50
78351	Bone mineral, dual photon	0.30	0.30
92015	Refraction	0.53	[2]0.38
92310	Contact lens fitting	1.18	1.18
92314	Prescription of contact lens	0.79	[2]0.64
92340	Fitting of spectacles	0.37	0.37
92341	Fitting of specatacles	0.51	[2]0.44
92342	Fitting of spectacles	0.59	[2]0.51
92370	Repair & adjust spectacles	0.49	[2]0.17
99431	Initial care, normal newborn	1.23	[2]0.74
99432	Newborn care not in hospital	1.28	[2]1.15
99433	Normal newborn care, hospital	0.64	[2]0.44
99440	Newborn rsuscitation	2.96	[2]0.92

[1] All numeric CPT HCPCS Copyright 1993 American Medical Association.
[2] Discussion of HCFA rationale for proposed work RVUs follows this table.

2. RUC Recommendations That Were Not Accepted

The following is a summary of our rationale for not accepting particular RUC recommendations for assignment of RVUs for CPT codes that will appear in the 1995 CPT. It is arranged by type of service in CPT code order. In this summary, all references to assignment of RVUs pertain only to work RVUs unless we specify that they pertain to practice expense RVUs, malpractice expense RVUs, or total RVUs.

a. *Reconstructive and cosmetic plastic surgery.* (1) Subcutaneous injection of "filling" material (CPT codes 11950 through 11952 and 11954). The four CPT codes in this series are based on the amount of "filling" material that ranges from less than 1 cc (CPT code 11950) to over 10 ccs (CPT code 11954). RUC recommended RVUs for each of these CPT codes of 1.23, 1.73, 2.47, and 2.71, respectively. We agree with the relative relationship among the CPT codes proposed by RUC but believe that the recommended RVUs are too high. We agree with RUC's use of CPT codes 11900 and 11901 (injection into skin lesions codes) as reference procedures. However, we do not believe that contouring involves as much work as RUC indicates. RUC recommended 1.23 RVUs for CPT code 11950, which is the injection of 1 cc or less. These RVUs are 50 percent higher than the RVUs for CPT code 11901 (0.81 RVUs), which involve the injection of more than seven lesions. We do not believe that the difference in RVUs is as great as RUC recommends. We also used CPT code 20610 (injection into a major joint or bursa) as another reference code. This procedure involves 0.80 RVUs. Recognizing that CPT code 11950 involves more work than either of the two reference codes, we propose assigning it 0.85 RVUs. To determine RVUs for the other three codes, we first accepted RUC's relative relationships for the family of CPT codes. We then

multiplied the ratio of .85 to 1.23 (69 percent) by the RUC-recommended RVUs for CPT codes 11951, 11952, and 11954, which resulted in RVUs of 1.20, 1.71, and 1.87, respectively.

(2) Punch grafts for hair transplants (CPT codes 15775 and 15776). We agree with RUC's use of CPT code 15050 (pinch graft) as a reference service for valuing these CPT codes. However, we believe that the recommended RVUs, 5.31 for CPT code 15775 and 7.44 for CPT code 15776, are too high. The reference CPT code 15050 has a 90-day global period, and the hair transplant codes have no global period. Using the Harvard research team's data for intraservice work and same day preoperative and postoperative work, we first reduced the RVUs for CPT code 15050 to 2.43 to make the global period comparable to that of the hair transplant codes. Because we believe that the work of CPT code 15775 is greater than that of a pinch graft but not double the work as RUC contends, we propose establishing 4.00 RVUs for CPT code 15775. We used the RUC relative relationships between these two codes to develop 5.60 RVUs for CPT code 15776.

(3) Preparation of moulage for custom breast implant (CPT code 19396). RUC recommended 2.96 RVUs based on a multiple of the RVU assigned to CPT code 99241 (office consultation for a new or established patient). We agree with RUC's use of an evaluation and management code as a reference service but believe this procedure is comparable to CPT code 99204 (a new patient office visit lasting about 45 minutes). Also RUC's recommended 2.96 RVUs are higher than those of CPT code 31622 (a bronchoscopy) although preparation of a moulage is of lower intensity. Therefore, we propose establishing 1.70 RVUs for this procedure.

(4) Rhinoplasty (CPT codes 30400, 30410, 30420, 30430, and 30435). We propose decreasing all of RUC's recommended work RVUs for these CPT codes. RUC's survey data indicated that these services require an average of six post-hospital visits, including two level 4 office visits (CPT code 99214). We believe that these data overestimate past hospital work; this, in turn, contributed to an overestimation of the total work. In developing an RVU for CPT code 30400, we used three procedures as reference services: thyroid lobectomy (CPT code 60220, 9.97 RVUs), appendectomy (CPT code 44950, 6.13 RVUs), and septoplasty (CPT code 30520, 5.61 RVUs). We believe that the work of CPT code 30400 is less than that of CPT code 60220 but more than that of both CPT codes 44950 and 30520. Therefore, we are proposing 8.85 RVUs for CPT code 30400. These RVUs are comparable to the RVUs recommended by the Harvard research team rather than the RVUs recommended by RUC.

In developing RVUs for CPT code 30410, we used major thoracotomy with exploration and biopsy (CPT code 32100, 10.18 RVUs) as a reference service. We believe that CPT code 30410 involves less work than a thoracotomy (CPT code 32100) and, therefore, prefer Harvard research team's recommended 9.95 RVUs, rather than the RUC recommendation of 13.82 RVUs. We used CPT codes 30410 and 30520 (septoplasty) as the reference services for CPT code 30420 by summing the RVUs of the two services after applying the multiple-surgery rule to reduce the RVUs for the lesser valued service (CPT code 30520) by 50 percent. This resulted in 12.76 RVUs for CPT code 30420.

The reference service we used for CPT code 30430 was a septoplasty (CPT code 30520, 5.61 RVUs). We believe a septoplasty requires slightly more work than CPT code 30430. Therefore, we propose assigning 5.60 RVUs. These RVUs are comparable to the Harvard research team's 5.60 RVUs, rather than RUC's recommendation of 7.40 RVUs.

Because we believe that CPT code 30435 involves a similar level of work to CPT code 30410 (9.95 RVUs), we used RUC's rank ordering of these two codes (RUC rated CPT code 30435 slightly lower than CPT code 30410) and, therefore, propose establishing 9.65 RVUs for CPT code 30435.

(5) Otoplasty (CPT code 69300). The full CPT description for this CPT code is "otoplasty, protruding ear, with or without size reduction." In valuing this procedure, we interpreted the description as describing a unilateral procedure. However, the RUC vignette described a bilateral procedure, and RUC recommended 10.86 RVUs. We believe that the work for this procedure is approximately half of a complete rhinoplasty (CPT code 30410, 9.95 RVUs), less than an appendectomy (CPT code 44950, 6.13 RVUs) and slightly less than a septoplasty (CPT code 30520, 5.61 RVUs). Therefore, we propose establishing 5.50 RVUs for CPT code 69300. Also, we propose to establish a global period of 90 days as recommended by RUC.

b. *Maxillofacial surgery—(CPT codes 21137 through 21139 and 21181).* We believe that the RUC-recommended RVUs for procedures associated with forehead reductions (CPT codes 21137 through 21139) are too high but are correct in relation to each other. For CPT code 21137, RUC recommended 11.84 RVUs. We disagree, since a total lobectomy (CPT code 60220), which we believe is more complicated, is assigned 9.97 RVUs. We believe that the work involved in performing CPT code 21137 is 95 percent of that required for a total lobectomy. Therefore, we propose lowering the RVUs for CPT code 21137 by 5 percent resulting in 9.50 RVUs.

Since we agree with the RUC's recommended relationship among the procedures, we propose reducing proportionately the RVUs for CPT codes 21138 and 21139. This results in an assignment of 11.85 RVUs for CPT code 21138 and 14.22 RVUs for CPT code 21139.

We propose lowering the 15.30 RVUs recommended by RUC for CPT code 21181 (reconstruction by contouring of benign tumor of cranial bones) to 9.50 making them the same for CPT code 21137. We believe this procedure is similar to that of CPT code 21137 and is more of a functional repair than a cosmetic repair and, therefore, the work involved is not as intense.

c. *Respiratory System—Laryngoplasty (CPT code 31582) for laryngeal stenosis, with graft or core mold, including tracheotomy.* We disagree with RUC's recommended 20.18 RVUs for CPT code 31582. We believe the work of CPT code 31582 is similar to that of CPT code 31780 (excision of tracheal stenosis and anastomosis), which has 16.32 RVUs. Therefore, we propose lowering the RVUs for CPT code 31582 to 16.32. This comparison is validated by a comparison with CPT code 31580 (11.19 RVUs), which involves 30 to 60 minutes less operative time and a shorter inpatient stay. A decrease of 5.13 RVUs adequately accounts for this difference.

d. *Vascular—Penile revascularization (CPT code 37788), artery with or without vein graft.* We disagree with RUC's recommended 22.70 RVUs. We believe this procedure is not much more difficult than CPT code 35656 (femoral-popliteal bypass graft), which is assigned 14.00 RVUs. Thus, we propose adding 1.00 RVU to the RVUs for CPT code 35656, which results in 15.00 RVUs for CPT code 37788.

e. *Vestibuloplasty (CPT codes 40840 through 40845).* We believe the RUC-recommended RVUs for the vestibuloplasty CPT codes 40840 (9.87), 40842 (9.87), 40843 (13.82), 40844 (18.26), and 40845 (21.32) are high in relation to other oral procedures. However, we do agree with the work relationship among the procedures. We believe that CPT code 40840 (anterior vestibuloplasty) is no more difficult than CPT code 14060 (adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 square cm or less), which is assigned 8.40 RVUs.

Therefore, we propose assigning 8.40 RVUs to CPT code 40840. This conclusion is supported by our belief that CPT code 40842 (unilateral posterior vestibuloplasty) is similar in nonoperative work to CPT code 40654 (complex lip repair) (5.19 RVUs). We consider the greater operative work (about 60 minutes) of CPT code 40842 to be worth the additional 3.21 RVUs that would give it the same total RVUs (8.40) as CPT code 40840. Since we agree with the relationship established by RUC among CPT codes 40843 through 40845 and CPT codes 40840 and 40842, we propose retaining that relationship by applying a reduction of 14.9 percent for each CPT code yielding 11.76 RVUs for CPT code 40843, 15.54 RVUs for CPT code 40844, and 18.14 RVUs for CPT code 40845.

f. *Urology.*

(1) Donor nephrectomy with preparation and maintenance of homograft from a living donor (CPT code 50320). We disagree with RUC's recommended 22.37 RVUs. We believe this procedure is equivalent to CPT code 50220 (nephrectomy including partial ureterectomy, including rib resection), which has 16.16 RVUs. Therefore, we would assign 16.16 RVUs to CPT code 50320.

(2) Plastic operation of penis for injury (CPT code 54440). We do not believe that the description for this procedure is sufficient to differentiate this procedure from the other plastic operation procedures of the penis (CPT codes 54352, 54360, 54380, 54385, and 54390), which have RVUs that range from 11.52 to 24.11. In addition, the description of the intraservice work furnished by RUC states that "the variations and severity of the injuries differ and each repair is predicated on the type of injury * * * No case is the same * * *." Thus, we do not believe there is sufficient clinical documentation to support RUC's recommended 11.84 RVUs, which would place it in the family of plastic operations of the penis.

Based on the description, we believe that the work reported for CPT code 54440 could be as justifiably compared to that of CPT code 13101 (complex repair, trunk, 2.6 cm to 7.5 cm), a procedure with 3.91 RVUs, as with the more complex family above. However, because of the lack of specificity in the CPT code description, we propose continuing allowing carriers to price this procedure.

(3) Suture or repair of testicular injury (CPT code 54670). RUC recommended 6.50 RVUs. We propose decreasing the RVUs for CPT code 54670 to 5.33 based on the determination that the work involved is comparable to the higher end of the spectrum of work associated with CPT code 13132 (complex repair, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet, 2.6 cm to 7.5 cm) (4.26 RVUs) and should be valued 25 percent more than CPT code 13132.

(4) Electroejaculation (CPT code 55870). RUC recommended 3.95 RVUs. We propose decreasing the RVUs to 0.30. We believe that the work is similar to a level 1 emergency department visit (CPT code 99281), which has 0.28 RVUs. Also, the work is much less difficult than an ultrasound of the rectum (CPT code 76872), which has 0.70 RVUs or a diagnostic anoscopy (CPT code 46600), which has 0.51 RVUs. We believe that the time estimates furnished in the RUC recommendation are too high. If more intraoperative work than a proctoscopy is required, such as a catheterization to retrieve semen, we propose that the appropriate unusual services CPT modifier −22 be reported.

g. *Ophthalmology.* (1) Determination of refractive state (CPT code 92015). RUC recommended 0.53 RVUs for this procedure, slightly less than the 0.56 RVUs for its reference service CPT code 99213 (a 15-minute office visit for an established patient). The RUC survey data, however, indicate that the intraservice time is 11 minutes. Because 11 minutes correlates more closely to CPT code 99212 (a 10-minute office visit for established patient), we used CPT code 99212 (0.38 RVUs) as the reference service. Because we believe a determination of the refractive state to have slightly less intensity (work per unit time), we propose establishing 0.38 RVUs for CPT code 92015.

(2) Prescription of optical and physical characteristics and fitting of contact lens and direction of fitting by an independent technician, except for aphakia (CPT code 92314). We accepted the RUC recommendation of 1.18 RVUs for the prescription and fitting of corneal lens, both eyes, except for aphakia (CPT code 92310). These RVUs are 93 percent of the published 1.27 RVUs for CPT code 92312, which is the same service for aphakic patients. By accepting the RUC recommendation for CPT code 92310, we created a relationship between CPT codes that describe the same procedure except that one is "for aphakia" and one is "except for aphakia." To be consistent in valuing the nonaphakic CPT codes at 93 percent of the comparable aphakic CPT codes, we propose reducing the RUC recommendation of 0.79 RVUs for CPT code 92314 to 0.64 RVUs by multiplying the RVUs of corresponding CPT code 93216 (0.69 RVUs) by 93 percent.

(3) Fitting of spectacles, except for aphakia (CPT codes 92340 through 92342). In this family of CPT codes, RUC recommended that the fitting of monofocal spectacles except for aphakia (CPT code 92340) should be assigned the same RVUs as CPT code 92352 (0.37 RVUs), which is the same service for aphakic patients. We agree with this equivalence. Also, we propose establishing 0.51 RVUs for CPT code 92342 using the published 0.51 RVUs for CPT code 92353, which is the corresponding CPT code for aphakia. This results in a decrease from the RUC-recommended 0.59 RVUs. For the bifocal service (CPT code 92341), we propose establishing 0.44 RVUs for this CPT code by identifying the midpoint between the RVUs for CPT codes 92340 (0.37 RVUs) and 92342 (0.51 RVUs). RUC recommended 0.51 RVUS, which is valued between the monofocal and multifocal services. Our proposal agrees with this rank order.

(4) Repair and refitting of spectacles, except for aphakia (CPT code 92370). RUC recommended 0.49 RVUs. We reject RUC's use of CPT code 99213 (office or other outpatient visit for the evaluation and management of an established patient, 0.56 RVUs) as a reference service because the median intraservice time of CPT code 92370 is 10 minutes and this procedure involves considerably less intensity than the work described under CPT code 99213. Since we believe the work intensity to be half that of an evaluation and management service, we propose establishing 0.17 RVUs for CPT code 92370, the same work value as CPT code 99211 (a 5 minute visit).

h. *Newborn care.* (1) History and examination of the normal newborn infant (CPT code 99431). RUC recommended 1.23 RVUs for this CPT code. We believe these recommended RVUs, which are 15 percent higher than a level 1 hospital admission (CPT code 99221, 1.07 RVUs), are too high. We generally agree with the description of the work furnished to RUC but do not agree that the vignette used in the survey is consistent with the CPT code. The vignette states that issues such as feeding, immunizations, and car safety are discussed with both parents. We do not believe these services are included in this CPT code. We also disagree that the examination of a normal newborn requires more mental effort and judgment than the admission of a sick child or adult to the hospital. Therefore, we propose reducing the RVUs to 0.74, which is similar to a level two new patient visit (CPT code 99202).

(2) Normal newborn care in other than a hospital or birthing room including physical examination of baby and conference(s) with parent(s) (CPT code 99432). RUC recommended 1.28 RVUs for this CPT code, which is 0.05 RVUs higher than the recommended RVUs for normal newborn care in the hospital (CPT code 99431). Unlike the CPT code for normal newborn care in the hospital, this CPT code does include counseling. Therefore, we are not proposing to decrease the RVUs of CPT code 99432 as much as we are proposing to decrease the RVUs of CPT code 99431. We agree with the reference CPT code 99203 (level 3 office visit with a new patient (1.15 RVUs). We propose assigning the same RVUs of 1.15 to this normal newborn care code.

(3) Subsequent hospital care for the evaluation and management of a normal newborn, per day (CPT code 99433). RUC recommended 0.65 RVUs for this CPT code. We disagree with these RVUs that are based on a comparison to a level 1 subsequent hospital care (CPT code 99231), which has 0.56 RVUs. The specialty society recommendation to RUC states that the work of the two CPT codes is the same but that more mental effort and judgment are needed. We disagree with this conclusion because we believe the intensity of work for a normal newborn is less than the intensity of work for a sick person in the hospital. Therefore, we propose assigning 0.44 RVUs to this CPT code.

(4) Newborn resuscitation (CPT code 99440). RUC recommended 2.96 RVUs based on a comparison to an hour of critical care (CPT code 99291, 3.68 RVUs) and surveyed intraservice time of 45 minutes. We believe this recommendation is too high because the 45 minutes of intraservice time does not correspond to the actual time spent resuscitating the infant. We believe the survey has inadvertently included stand-by time for the C-section delivery that should be reported under CPT code 99360. We agree that the critical care CPT code 99291 is the appropriate reference but believe a more typical time for newborn resuscitation would be 10 to 15 minutes. Therefore, we propose establishing 0.92 RVUs based on 15 minutes of physician work time compared to the critical care CPT code 99291 (3.68 RVUs) (3.68/4=0.92).

3. Comment Process for Proposed RVUs

We will consider timely comments received on these proposed RVUs in developing final RVUs to be announced in the **Federal Register** in the fall of 1994, to be effective January 1, 1995.

While we welcome comments in any format, we have found from past experience that the most useful comments have followed a particular format. We prefer receiving a clinical description of the service in question, and how the work of that service is analogous to one or more suitable reference services. Reference services should be commonly performed services with established work RVUs that are also fairly well understood outside their specialty. We have included a list of suggested reference services in Addendum G. On this list we have included the following services:

- Services that are commonly performed.
- Services that span the entire spectrum of work RVUs.
- At least three services furnished by each of the major specialties.

If none of these services is suitable, we recommend choosing another service from the physician fee schedule and explaining why it is a better reference procedure.

The clinical analogy for many services can be strengthened by dividing the service into the following three time segments and comparing these segments with the respective segments of the reference services:

- Preservice work—Work performed before the actual procedure such as review of records, solicitation of informed consent, and preparation of equipment. For surgical procedures with global periods, include estimates of the number, time, and type of visits from the day before surgery until the time the patient enters the operating room. The visit when the decision to operate is made and those visits preceding it should not be included.
- Intraservice work—The actual performance of the procedure. For evaluation and management services, this would be described as "face-to-face" time. For surgical procedures, include the entire time period from when the patient enters the operating room until the patient is discharged from the recovery room.
- Postservice work—Analysis of data collected from the encounter, preparation of a report, and communication of the results. For surgical procedures with global periods, include the number, time, and type of surgeon visits from the time the patient leaves the recovery room until the end of the global period. Also, distinguish inpatient from outpatient visits.

In making these estimations, we encourage detailed clinical information such as data derived from operating logs, operative reports, and medical charts concerning the length of service, the amount of work performed before and after the service, and the length of stay in the hospital. The usefulness of these data is greatly enhanced if they are presented with comparable data for reference services. Also, we encourage evidence of why the data presented are nationally representative of the average work involved in providing the service.

The concept of work involves more than just time; it is the product of time and "intensity". Intensity is best compared by breaking it into the following elements:

- Mental effort and judgment—Compare the service in question with a reference service as to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the complexity of how these factors interact.
- Technical skill and physical effort—One useful measure of skill is the point in training when a resident is expected to be able to perform the procedure. Physical effort can be compared by dividing services into tasks and making direct comparisons of tasks. In making comparisons, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting.
- Psychological stress—Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when outcome is heavily dependent on skill and judgment and a mistake has serious consequences. The second relates to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be a highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. One common mistake is to "anchor," to treat points of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum is an accurate reflection of the average intensity of a service: a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

4. Establishment of Practice Expense and Malpractice Expense RVUs

• To the extent possible, we would use Medicare charge data to establish practice expense and malpractice expense RVUs for these codes. The RVUs would be calculated according to the statutory formula that requires us to apply historical practice cost shares to a base allowed charge for the service. To determine the practice cost shares, we would use data from the AMA's Socioeconomic Monitoring Survey for physician specialties.

If Medicare charge data do not exist, are insufficient, or are unreliable for reasons such as variations in interpretation of the code, we propose to establish practice expense and malpractice expense RVUs by one of several extrapolation techniques. For example, if we have already established RVUs on the basis of reliable charge data for an analogous procedure with similar practice expenses, we propose to use the charges for the analogous code. If there is no analogous code, we would impute the practice expense and malpractice expense RVUs from the work RVUs. Essentially, we would derive the total RVUs from the work RVUs and then apply the practice cost shares for the specialty most closely associated with the procedure to determine the practice expense and malpractice expense RVUs. For example, if a procedure has 6.00 work RVUs, and the specialty practice cost percentages for the specialty furnishing the service are 60-percent work, 30-percent practice expenses, and 10-percent malpractice, then the total RVUs are 10.00 (6/.60), the practice expense RVUs would be 3.00 (.30 x 10), and the malpractice expense RVU would be 1.00 (.10 x 10).

D. Separate Payment for Physician Care Plan Oversight Services

1. Background

Under current Medicare policy, separate payment is not made for physician care plan oversight services. While the services are covered, they are considered part of the physician work involved in other services, both visits and procedures; payment for the visit or procedure encompasses payment for these services. We continue to believe that most of the tasks associated with care plan oversight are of this type and are accounted for in the pre- and post-work RVU components for the visit. However, we are aware that, in certain situations, physicians furnish significant medical management services for which our current policy may not provide adequate payment.

In the July 1993 **Federal Register**, we solicited comments regarding a possible policy change to pay separately for case management services. We received comments from specialty groups and individuals indicating that physicians spend considerable time furnishing these services to patients. Most commenters believed that we should pay separately for these services and supported the use of the CPT codes for care plan oversight (99375 and 99376), which were established in 1994. We believe the term "care plan oversight" more accurately describes the services referred to in our proposed rule than the term "case management."

The CPT defines care plan oversight (CPT code 99375) as "physician supervision of patients under care of home health agencies, hospice or nursing facility patients (patient not present) requiring complex or multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a 30-day period; 30–60 minutes." The second code, CPT code 99376, is for services requiring more than 60 minutes of physician time. These codes are included in the 1994 fee schedule as codes that are bundled into the visits or other procedures; separate payment for them is not allowed.

We propose to allow separate payment for care plan oversight services furnished in 1995 but only for the oversight of beneficiaries who are receiving Medicare covered home health care services. We do not propose to recognize separate payment for care plan oversight for beneficiaries in hospices, beneficiaries under the care of a home health agency (HHA) but not receiving covered home health care, and beneficiaries residing in skilled nursing facilities (SNFs) and nursing facilities (NFs). Our reasons follow.

With respect to patients who are under the care of HHAs who are not receiving Medicare covered HHA benefits, we do not believe that many cases require the type of complex care plan oversight for which we are proposing to pay. Some of these patients are not homebound and could see the physician in the office (although absences from the house to receive medical treatment do not affect a patient's "homebound" status for purposes of qualifying for home health benefits). Other patients are receiving nonskilled services and do not require substantive care plan oversight. With respect to hospice patients, we do not believe that we should allow a separate payment for care plan oversight services furnished to these patients because payment for these services is included in the prospective rates paid to the hospices. Separate payment for complex medical management would result in a duplication of Medicare payments for these services when furnished to hospice patients.

As to SNF and NF patients, the work RVUs for the SNF and NF evaluation and management codes for new or established patients were specifically increased in 1993 by 0.21 for CPT code 99301, 0.63 for CPT code 99302, 0.91 for CPT code 99303, 0.07 for CPT code 99311, 0.22 for CPT code 99312, and 0.21 for CPT code 99313 to account for care plan oversight performed in conjunction with those visits. Physicians are required to see patients in SNFs for an initial comprehensive assessment at least once every 30 days for the first 90 days and at least once every 60 days thereafter. Also, physicians are required to perform reassessments annually and after any episodes when the patient's condition changes significantly. Therefore, the frequency of visits and payment for periodic reassessments ensure that physicians receive payment for care plan oversight services furnished to SNF patients.

Although the home visit codes were also increased in 1993, we do not believe that a similar conclusion can be made for HHA patients since there is no direct correlation between those patients and the home visit codes. Further, the amount of care plan oversight required for HHA patients can be considerable. While we currently wish to limit payment for care plan oversight services to those furnished to patients receiving HHA services that are covered by Medicare, we will reconsider our decision to pay for these services in other situations in the future if we find good cause to do so.

Since the conditions for which we would pay for these services differ from the CPT definition, we propose to establish a new alpha-numeric code (level 2 HCPCS code).

2. Physicians Eligible to Receive Payment

We believe, in general, only one physician is responsible for signing the plan of care for HHA patients. Furthermore, because the complex care plan oversight services for which we

would pay require at least 30 minutes per month per patient, we believe that only one physician per month would meet our requirements. This policy conforms with the CPT instructions that only one physician may report services for a given period of time. We consider the care plan oversight services that are directly related to a surgical procedure and furnished during the global period of the surgery to be included in the global fee for the procedure. However, surgeons can be paid for care plan oversight during the global fee period if the service is not related to the surgery. (Modifier -24 with documentation would be used to report these services.) We expect that most of these services would be reported by primary care physicians.

We would not allow payment to a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, an HHA (see § 424.22(d) regarding the limitations on certification of home health services).

3. Level of Payment

We propose to establish one level of payment for all care plan oversight services requiring at least 30 minutes per month. We do not propose to establish a second level of payment for care plan oversight activities requiring 60 or more minutes, as indicated by the CPT definitions, because we believe that the typical case for which we propose payment requires 30 to 60 minutes per month.

We believe the physician work involved in care plan oversight is similar to that described as hospital discharge day service (CPT code 99238), and we would assign the same level of RVUs to the code we establish for care plan oversight. Currently CPT code 99238 is assigned 1.63 total RVUs (1.07 work, 0.52 practice expense, and 0.06 malpractice). We propose to subject these services to the CF for nonsurgical services other than primary care. We will make a final determination, based upon our review of the public comments, in the final rule.

4. Budget Neutrality

As indicated above, we do not consider care plan oversight to be a new service. Medicare payment to the physician for covered visits and procedures has always included payment for covered care plan oversight services. Medicare has never paid separately for these covered services under the physician fee schedule. We also believe our long-standing policy of bundling care plan oversight into the primary service furnished by the physician has reflected physicians' historic billing practices in this regard. Since we do not consider care plan oversight to be a new service but rather an "unbundling" of the service from payment for existing services, we consider this a change requiring a budget neutrality adjustment.

Section 1848(c)(2)(B) of the Act provides that adjustments in RVUs may not cause total fee schedule payments to differ by more than $20 million from what they would have been had the adjustments not been made. We believe it is appropriate to adjust RVUs across all physician services to pay an additional amount for this service under the conditions described below.

We would consider this adjustment to be "interim" for three years, during which time we would monitor the use of this service. If the use of this service is determined to be significantly higher than expected, we would make an additional adjustment to achieve budget neutrality.

5. Conditions for Payment

We propose to allow separate payment for care plan oversight for a patient receiving HHA services that are covered by Medicare. The care plan oversight services must require recurrent physician supervision of therapy (patient not present) involving 30 or more minutes of the physician's time in a 30-day period. The patient must require complex or multidisciplinary care modalities involving regular physician development or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan, or adjustment of medical therapy. Since the conditions for which we would pay for these services differ from the CPT definition, we would establish a level 2 HCPCS code with the aforementioned definition.

We would allow payment to one physician per patient during a 30-day period. We would not allow payment to a physician who has a significant financial or contractual relationship with an HHA (§ 424.22(d)). Furthermore, we would not allow payment unless the physician has seen the patient within the 6-month period before the 30-day period for which the physician first bills for care plan oversight to ensure physician involvement in establishing the plan of care.

We would pay for this service during a global period of another service if the care plan oversight is documented to be unrelated to the surgery and identified by modifier -24. However, we would not pay for this service during the same month a physician bills for the hospital discharge under CPT code 99238 because the payment for CPT code 99238 includes payment for care plan oversight.

Physicians must document in their records the care plan oversight services they furnish, including the duration of time spent on the services for which payment is claimed. We plan to conduct post-pay monitoring on the use of these codes. The monitoring may be performed on a sample basis or focused on physicians who are high users of the code. The purpose of the monitoring would be, in part, to furnish additional provider education on the proper use of the code and the conditions for which Medicare recognizes payment.

While we are proposing to establish an allowance for home health care plan oversight under the physician fee schedule, we have two major concerns that need to be resolved before we would implement the proposal. The first concern relates to the interaction of this proposal with another initiative to improve the Medicare home health benefit. We have begun a major review of this benefit and will be working with beneficiary and provider groups and other interested parties. Our examination will include the recent rapid cost growth as well as options for simplifying the benefit. Another purpose of this initiative is to examine options for assuring the quality of care and enhancing outcomes. Some of these options may require legislation. While this proposed rule is intended to reimburse physicians for carrying out responsibilities currently mandated by Medicare, the new home health initiative will also examine all home health requirements, including care plan oversight. One specific issue is the extent to which nurse practitioners and clinical nurse specialists can substitute for physicians in overseeing certain aspects of patient care. The OBRA '89 amendments, for example, permit nurse practitioners and clinical nurse specialists to certify and recertify SNF care when working in collaboration with a physician. Therefore, we would like comments from beneficiaries, their families, consumer groups, physicians, nurses, and HHA providers regarding the following issues:

- To what extent are physicians involved in developing, monitoring, and altering the plan of care? What specific management activities do they perform

and for what proportion of their caseload do these activities require 30 or more minutes each month?

- Which patient characteristics or services require physician case management and which do not?
- Can some patients who require case management be safely managed by nurses or nurse practitioners rather than physicians, and if so, what are their characteristics?
- Are there any lessons relevant to home health from the SNF experience in which nurse practitioners and clinical nurse specialists have been permitted to certify SNF care?

We will consider the responses to these questions as well as recommendations resulting from the home health initiative when deciding whether to adopt or modify this proposal to reimburse physicians separately for care plan oversight services effective January 1, 1995.

Our second major concern relates to the impact of the provision on beneficiaries, that is, additional beneficiary liability due to the coinsurance payments for care plan oversight. Since we would implement this in a budget-neutral manner by reducing the RVUs for all other services, the coinsurance amounts for all other physician services would actually decrease. We estimate that the average HHA beneficiary will be liable only for approximately $16 in coinsurance for care plan oversight services per year. We believe that approximately 75 percent of these beneficiaries have some type of supplemental insurance that will cover the additional coinsurance amount.

Also, we are aware of concerns that beneficiaries may be liable for additional out-of-pocket expenses for services that they may not realize are being provided because the work in care plan oversight does not necessarily require a face-to-face encounter between the patient and the physician. We will work with HHA and physician groups to encourage providers to inform beneficiaries that physicians may bill and that Medicare will pay for these services when the specified conditions are met. Our discussions with medical societies indicate that physicians would do this as a matter of course. In addition, we would advise beneficiaries of this change in policy through special mailings or in the Explanation of Medicare Benefits.

We considered requiring beneficiaries to designate a particular physician as the provider of care plan oversight. However, designating a physician would not qualify that physician for payment if the conditions were not met and could, therefore, place an unnecessary burden on the patient or the patient's family. In addition, it would be difficult and costly for the carriers to administer.

Our reason for proposing separate payment for care plan oversight is to provide fair compensation for services physicians are already required to perform. Also, it has been suggested that paying for these services could be an incentive for greater physician involvement in the care of HHA beneficiaries.

We request comments on all aspects of our proposal, and are particularly interested in receiving comments from beneficiaries, their families, beneficiary advocacy groups, physicians, and HHAs on beneficiary liability concerns.

E. Payment for Multiple Surgical Procedures

We propose to revise our regular multiple surgery reduction rules to base payment on the lesser of the actual charge or 100 percent of the fee schedule amount for the procedure with the highest fee schedule payment and to base payment on the lesser of the actual charge or 50 percent of the fee schedule amount for the second through the fifth surgical procedures when the procedures are performed on the same patient on the same day by the same surgeon. Surgical procedures beyond the fifth procedure would be priced by carriers "by report" based on documentation of the services furnished.

We currently reduce payment for subsequent surgeries when a physician performs more than one surgery on a patient on the same day. We also reduce payment for the second procedure when a physician does a bilateral procedure (for example, bilateral knee replacements). We implemented the multiple and bilateral surgery reduction policies when the fee schedule was implemented in 1992 because carriers had historically reduced payment when more than one surgery was performed by a physician for a patient on the same day. The carriers and we believed that there was less physician work involved when a physician did multiple procedures on the same day than when the surgeries were performed separately.

We currently have three different sets of multiple surgery rules: special dermatology rules, special endoscopy rules, and standard multiple surgery rules. The special dermatology rules base payment for the highest priced procedure on the lesser of the actual charge or 100 percent of the fee schedule amount, base payment for the second through fifth procedures on the lesser of the actual charge or 50 percent of the fee schedule amount, and base payment for subsequent procedures "by report." The special endoscopy rules base payment for the highest priced procedure on the lesser of the actual charge or 100 percent of the fee schedule amount (unless the regular multiple procedure rules apply to it) and base payment for subsequent procedures in the same endoscopy family on the incremental increase in payment over the base code. We are not proposing changes to the special dermatology rules or the endoscopy rules.

The standard multiple surgery rules that apply to most other surgical procedures require carriers to rank the procedures by payment amount in descending order and base payment for the highest priced procedure on the lesser of the actual charge or 100 percent of the fee schedule payment. Carriers base payment for the second procedure at 50 percent; the third, fourth, and fifth procedures at 25 percent each; and procedures subsequent to the fifth procedure "by report." In addition, the bilateral procedure policy (a variation of multiple surgery but treated as a different policy) requires carriers to base payment for the first procedure on the lesser of the actual charge or 100 percent of the fee schedule payment and to base payment for the second procedure on the lesser of the actual charge or 50 percent of the fee schedule payment for the code.

Many physicians have objected to the standard multiple procedure reductions. They believe the work included in the global payment for the surgery is not reduced when they do more than one procedure on the same day and, therefore, that they should be paid the full global fee for all procedures they perform on a patient on the same day. As a result of these comments, we contracted for a study of the work in multiple and bilateral surgical procedures. This study was performed by the research team at the Harvard School of Public Health that furnished the data on which the work RVUs for many services in the fee schedule are based. The results of this study are available from NTIS by calling 1–800–553–NTIS, or (703) 487–4650 in Springfield, Virginia and requesting the following study:

- "A National Study of Resource Based Relative Value Scales for Physician Services: MFS Refinement Final Report; Phase IV." Hsiao, Braun, Dunn, Cohen, Dernberg, Sacher, and Stamenovic. Department of Health Policy and Management, Harvard

School of Public Health. HCFA contract 500–92–0025. July 30, 1993. NTIS PB94–115094.

The Harvard study found that when more than one procedure is performed on the same day, the level of physician work for each subsequent procedure is approximately 50 percent of what the work would have been had each procedure been the only procedure performed that day. This finding implies that an appropriate multiple surgery reduction would be to pay 100 percent for the highest priced procedure and 50 percent for the second and subsequent procedures. In addition, the Harvard study found that when the physician performs a bilateral procedure, the work required by the second procedure is only 40 percent of the work that would have been required had both procedures not been done on the same day.

Based on the findings of this study, we propose to revise the current multiple surgery policy to base payment on the lesser of the actual charge or 100 percent of the fee schedule for the highest priced service and the lesser of the actual charge or 50 percent of the fee schedule for the second through the fifth services. Under this proposed change, the standard multiple surgery policy would be identical to the current special dermatology policy that now applies to some dermatology services. This change would also simplify Medicare policy because we would have two rather than three multiple surgery policies since the services now under the special dermatology policy and those under the standard multiple surgery policy would be under the same multiple surgery policy.

Carriers would continue to pay for surgical procedures subsequent to the fifth procedure on a "by report" basis. We believe that this review of the documentation for procedures after the fifth procedure is necessary to ensure proper coding and payment for these services. The frequency of more than five surgeries performed by the same physician on the same day is very small, and the study did not look at these occurrences. Moreover, our CMDs advise us that review of these occurrences often results in a determination that the services are incorrectly coded, or, rarely, a finding that the case is an extraordinarily difficult situation in which more payment may be appropriate than the multiple surgery rules would otherwise permit. Therefore, we continue to believe that "by report" review and payment is appropriate for the sixth and subsequent procedures performed on the same day.

We are not proposing any changes to the current policy for payment of bilateral procedures at this time, notwithstanding the findings of the Harvard study that it may be appropriate to decrease our payment from 150 percent to 140 percent when the service is bilateral. As we indicated above, the bilateral policy is a variation of the multiple surgery policy. We prefer to retain a consistent policy of payment at 50 percent for a second surgical procedure performed on the same day as another surgery even when the second procedure is the same CPT code as the first.

F. Application of Site-of-Service Payment Differential

Services that are performed more than 50 percent of the time in office settings are subject to a payment limit if they are performed in hospital outpatient departments and inpatient settings. For these procedures, the practice expense RVUs are reduced by 50 percent. This limitation reflects the fact that practice expenses are lower for services performed in hospital settings using hospital equipment, personnel, and space. Because procedures that are on the list of Medicare-approved ASC procedures are generally furnished less than 50 percent of the time in office settings, these procedures are not subject to this reduction.

We used 1989 data to establish the current list of ASC procedures subject to this site-of-service limitation. We propose to update this list using 1993 data to be effective for services furnished on or after January 1, 1995. To avoid any concern about the statistical validity of the data for low volume procedures, we would exclude any procedure performed less than 100 times annually. However, if the procedure is part of a "family" of codes that are otherwise on the site-of-service list, we would include it even if the volume is less than the 100-procedure threshold. (The current list excludes all procedures with volumes less than 1,000 in 1989.)

In addition, we propose to add certain procedures to the list that were proposed for removal from the list of approved ASC procedures. (The proposed notice listing the proposed deletions was entitled "Proposed Additions to and Deletions from the Current List of Covered Procedures for Ambulatory Surgical Centers" and was published in the **Federal Register** on December 14, 1993 (58 FR 65357).) If these procedures are ultimately not removed from the ASC list by the time we publish the final rule, the procedures would not be included as additions to the list.

The procedures we propose to add to the site-of-service list based on the more current data and the criteria outlined above are in Addendum H. We propose removing the following procedures from the site-of-service list:

HCPCS	Description
29530	Strapping of knee.
36425	Establish access to vein.
36500	Insertion of catheter, vein.
64425	Injection for nerve block.
64640	Injection treatment of nerve.
92018	New eye exam and treatment.
96440	Chemotherapy, intracavitary.
99275	Confirmatory consultation.

G. Bundled Services

1. Generation and Interpretation of Automated Data (CPT Codes 78890 and 78891)

The CPT states that CPT codes 78890 and 78891 should be reported in addition to a primary procedure. The Medicare charge data show that in 1992 (the latest year for which we have complete data), CPT codes 78890 and 78891 were billed in addition to a primary procedure only 12.7 percent and 2.5 percent of the time, respectively. The data indicate that these codes are being used incorrectly.

In addition, the work involved in the primary procedures with which CPT codes 78890 and 78891 have been billed includes the generation and interpretation of automated data. The RVUs for these primary procedures, for example, nuclear medicine procedures and cardiac stress tests, include a data component.

Therefore, we propose to bundle payment for CPT codes 78890 and 78891 into the payment for the primary procedure and assign a "B" status indicator to show that payment would be bundled into the payment for another service. By bundling these CPT codes, we avoid paying twice for the same service. We do not believe that separate payment should be made for these codes. We would redistribute the RVUs associated with CPT codes 78890 and 78891 across all codes.

2. Noninvasive Ear or Pulse Oximetry (CPT Code 94760)

At present, we allow separate payment for pulse oximetry testing (CPT code 94760) under the fee schedule. However, we believe this is a simple monitoring test that should be considered part of the larger procedure with which it is performed. Pulse oximetry is performed either as part of

anesthesia monitoring or as part of a study or assessment such as sleep studies and pulmonary function tests. Therefore, we propose to assign a "B" status indicator to CPT code 94760. Thus, payment for this procedure would be bundled into the RVUs of the procedure requiring the pulse oximetry testing. Because pulse oximetry may be performed in conjunction with a variety of physician services, we propose to implement this in a budget-neutral manner by redistributing the current RVUs across all services.

H. RVUs for Doppler Echocardiography (CPT Code 93325)

We are proposing to redistribute the RVUs assigned to CPT code 93325 (Doppler color flow velocity mapping). In 1992, the procedure was classified as a technical component (TC) service only (without a professional component (PC)). As a result of the refinement process for physician work RVUs, for 1993 we assigned 0.07 physician work RVUs to the code, and we established a PC for the procedure. We redistributed slightly more than half of the practice expense and malpractice RVUs to the PC from the TC. As a result, the PC was assigned 0.07 work RVUs, 1.44 practice expense RVUs, and 0.13 malpractice RVUs, and the TC was assigned 1.40 practice expense and 0.12 malpractice RVUs. While physicians and other entities billing for the complete or global services were unaffected by this change, physiological laboratories billing the TC saw their payments reduced by more than one-half. As a result of comments received, we propose to adjust the practice expense and malpractice RVUs as follows:

Modifier	Work	Practice expense	Malpractice	Total
−26	0.07	0.04	0.01	0.12
TC	0.00	2.79	0.24	3.03
Global	0.07	2.83	0.25	3.15

The practice expense and malpractice RVUs were determined by using practice expense data for cardiovascular disease specialists and extrapolating from the work RVUs using the methodology discussed in the November 1991 final rule (56 FR 59569).

I. Nuclear Medicine

The American College of Nuclear Physicians and The Society of Nuclear Medicine have brought a matter to our attention involving certain nuclear medicine multiple diagnostic procedures. The issue was not previously addressed in our regulations or instructions. The organizations noted that most carriers are denying payment for one of the procedures when both are performed on the same day. They also believed that, for patients with certain malignancies, it is necessary to perform a whole body planar study before a SPECT study, both to determine if tomography is needed and to deduce the region to be selectively imaged. They proposed that the CPT modifier −51 for multiple procedures be used in these situations, which would result in full fee schedule payment for the procedure with the highest payment level and a 50-percent payment for the second procedure. The procedures in question follow:

- CPT code 78306 (Bone imaging; whole body) when followed by CPT code 78320 (Bone imaging; SPECT).
- CPT code 78802 (Radionuclide localization of tumor; whole body) when followed by CPT code 78803 (Tumor localization; SPECT).
- CPT code 78806 (Radionuclide localization of abscess; whole body) when followed by CPT code 78807 (Radionuclide localization of abscess; SPECT).

We propose to implement the suggestion for the 1995 physician fee schedule.

J. End-Stage Renal Disease (ESRD)

1. Hospital Inpatient Dialysis on the Same Day as an Evaluation and Management Service

Presently, under the physician fee schedule we pay for the physician services associated with dialysis (CPT codes 90935, 90937, 90945, and 90947) in hospital inpatient settings. (In outpatient settings, these services are included in the monthly capitation fee (CPT codes 90918 through 90922).) Hospital inpatient dialysis is considered to be a global service; that is, a single fee is paid for all necessary services normally furnished with the procedure. Hospital inpatient dialysis has been assigned a 0-day global period. This means that payment is not made for a visit by the same physician on the same day that he or she bills the dialysis service unless the visit was not related to the treatment of the patient's ESRD and the service was not, and could not have been, furnished during the dialysis treatment.

In general, for evaluation and management services furnished in hospital settings, only one evaluation and management service can be billed per day. This includes, for example, multiple hospital visits on the same day and a hospital visit and inpatient psychotherapy service. One of the few exceptions that existed was ventilation management; however, effective January 1, 1994, payment is not made for both ventilation management and a hospital visit on the same day as stated in the December 1993 final rule (58 FR 63640). We consider physician dialysis services to be an evaluation and management service and believe dialysis should be treated similarly to all other evaluation and management services. Like ventilation management, dialysis management consists of evaluating the patient, making medical decisions, and writing orders for therapy to be furnished by hospital staff. Therefore, we propose to pay for either an evaluation and management code or a dialysis code, but not both, on the same day. Thus, physicians would no longer be paid for dialysis in addition to an evaluation and management service, even if the evaluation and management service is billed under CPT modifier -25.

In selecting the level of evaluation and management service to bill, physicians may, as indicated above, bill either the hospital visit or the dialysis service. Moreover, in selecting the level of the hospital visit that may be billed, the physician could consider the management of dialysis in determining the appropriate level of evaluation and management code. If it is appropriate, the physician may also bill the applicable prolonged service code in addition to the evaluation and management code. If a dialysis service and an evaluation and management service performed on the same day are both billed, the dialysis service may be paid, but the evaluation and management service will be rejected.

We propose implementing the proposal in a budget neutral manner by redistributing the payment for an evaluation and management service performed on the same day as dialysis into the payment for the dialysis service. We would determine the

current evaluation and management payment allowed when dialysis and evaluation and management are performed on the same day and make the appropriate adjustments to the work, practice expense, and malpractice RVUs to each of the four dialysis codes so that the payments remain budget neutral.

The following example using CPT code 90935 illustrates the proposed methodology for increasing the work, practice expense, and malpractice RVUs:

- Determine the aggregate allowed amounts and allowed services for CPT code 90935 (hemodialysis with a single physician evaluation).
- Determine the aggregate allowed amounts for the evaluation and management services performed on the same day as CPT code 90935.
- Divide the aggregate allowed payment for CPT code 90935 and evaluation and management services performed on the same day by the product of the sum of the national CF and the aggregate allowed services for CPT code 90935. This computation results in the increased total RVUs for CPT code 90935.
- Apportion the additional RVUs to the work, practice expense, and malpractice RVUs currently assigned to CPT code 90935 based on the current RVU shares.

2. Payment for Outpatient ESRD-Related Services Under the Physician Fee Schedule

a. *Development of the monthly capitation payment (MCP).* The MCP was implemented in 1983 in accordance with section 1881(b)(3) of the Act. It is a prospective, comprehensive, monthly payment for all outpatient ESRD-related physicians' services. The payment amount was originally set based on the most current reasonable charge data available (fiscal year (FY) 1981) for internists' office visits for established patients adjusted by a factor for home dialysis patients, reflecting the fact that physician effort for a home patient is 70 percent that of a facility patient. The payment amounts for the original MCP ranged from a minimum of $144 to a maximum of $220 reflecting the geographical variation in physicians' billing patterns. In 1985, the General Accounting Office (GAO) found that the relative physician effort for home dialysis patients should have been 26 percent of the effort for a patient dialyzed in a facility (GAO study GAO/HRD–85–14). Accordingly, in 1986, the MCP was reduced resulting in a current range of payment amounts from a minimum of $132 to a maximum of $203 and an average of approximately $180. These services are reported with CPT codes 90918 through 90921.

b. *Proposed inclusion of the MCP under the physician fee schedule.* We are proposing to include the MCP (CPT codes 90918 through 90921) under the physician fee schedule. Physicians' services are defined in section 1848(j)(3) of the Act as items and services described in, among other provisions, section 1861(s)(1). Those section 1861(s)(1) physicians' services include services furnished to beneficiaries with ESRD. However, at the inception of the fee schedule, we relied on the authority in section 1848(j)(3) to exclude these services from the fee schedule, in part because the authority to pay a comprehensive monthly rate for services to ESRD patients was derived from section 1881(b)(3).

We now propose instead to include the physicians' monthly routine professional services furnished to ESRD patients in the fee schedule. We believe, and understand that the nephrologists agree, that payment for these services should be established in the same way as all other physicians' services.

We are not proposing RVUs for these codes at this time. While the Harvard Phase I study assigned a work RVU of 1.60 RVUs to the service, concerns were expressed about the vignette used to survey the procedure. In light of these concerns and since RUC is currently reviewing the work for this service, we are not proposing an RVU now. Rather, we are requesting comments from nephrologists and other interested parties on the work RVU for this service and the basis for their recommendations. Commenters may consider the original Harvard RVU, the results of the RUC process, and any other information in making their recommendations. We plan to take these comments and the RVU proposed by RUC into account in establishing an interim final work RVU for the service for 1995. As with all interim RVUs, the RVU will be subject to comment and may be modified based on these comments for services furnished in 1996.

We propose to base the practice expense and malpractice expense RVUs on current payment allowances by applying the nephrologists' practice expense shares to the current allowance. We would apply the nonsurgical update to these codes. The MCP is paid to physicians for physicians' services. Therefore, this change will have no impact on payments to ESRD facilities for facility services.

K. Services Considered To Be Medicare Part A Services

Therapeutic apheresis (CPT code 36520) is included in the current fee schedule as a professional service with work RVUs. However, after further consideration, we do not believe this service requires physician work but rather that it is performed by the physician's staff. Moreover, because this procedure is usually performed in a hospital by hospital staff, payment is part of the Part A payment to the hospital. Therefore, we propose to remove the physician work RVUs for this code from the fee schedule and make this code an "incident-to" service on the fee schedule. The practice expense and malpractice expense RVUs for CPT code 36520 were originally calculated on a historical charge basis. We recalculated those RVUs for the "incident-to" code using the historical charges for this procedure. We propose to assign the following RVUs for this "incident-to" service: Practice expense—1.87; malpractice expense—0.12; total RVUs—1.99. Under this proposed rule, the code could be billed for the service only if it is performed in the office. The savings resulting from this proposal would be included in the budget-neutrality calculations for CY 1995.

III. Implementation of Omnibus Budget Reconciliation Act of 1993—Payment for Antigens (Allergen Immunotherapy)

A. Background and Legislative Change

Under allergen immunotherapy, patients with allergies are injected subcutaneously with extracts of the specific agents to which they are allergic. At the outset, small amounts are injected, but the dosage is gradually increased until a maintenance level is achieved and the patient is desensitized. The allergen extracts used for this therapy are called antigens.

Medicare coverage for antigens prepared by a physician is established in section 1861(s)(2)(G) of the Act, and they are currently paid for under the reasonable charge payment method. Unlike many other services for which Medicare payment is made to physicians, antigens were not included within the scope of services paid under the Medicare physician fee schedule. This was changed by section 13518 of OBRA '93. Subject to the Secretary's discretion, that section made services covered under section 1861(s)(2)(G) of the Act—that is, antigens prepared by a physician—subject to the Medicare physician fee schedule. This change is effective for services furnished beginning January 1, 1995.

In this proposed rule, we describe the RVUs and other policy provisions that we plan to implement in bringing antigens under the Medicare physician fee schedule.

B. CPT and HCPCS Codes

There are five J codes (level 2 HCPCS codes) that represent antigens in the 1994 HCPCS. Those codes are:

HCPCS code	Description
J0220	Injection, allergy desensitization, aqueous preparation.
J0230	Injection, allergy desensitization, Allpyral.
J0240	Injection, allergy desensitization, emulsion not specified.
J7010	Vial of allergy vaccine, single dose.
J7020	Vial of allergy vaccine, multiple dose.

These codes are infrequently used and do not represent a significant number of Medicare-allowed charges. (In 1993, there were only about 380,000 allowed services, representing $2.3 million.) Instead of using these J codes, most physicians bill for antigens under appropriate CPT codes. We are proposing to eliminate the use of these antigen J codes, thereby requiring all physicians to bill under the CPT codes.

To understand the antigen CPT codes and their use by allergists, we consulted with the Joint Council of Allergy and Immunology (JCAI). The JCAI is an organization of allergists and immunologists whose sponsors are the American Academy of Allergy and Immunology and the American College of Allergy and Immunology.

Within the CPT codes there are currently three types of codes. The first type is the injection-only code. It does not include the extract or the preparation of the extract. CPT code 95115 represents a single injection, and CPT code 95117 represents multiple (that is, two or more) injections. Because they do not include antigen extract, these codes are already being paid under the Medicare physician fee schedule and have been paid in that manner since fee schedule payments began in January 1992.

The second type of antigen code is the extract/extract preparation code. These codes represent the preparation of the antigen, the antigen extract itself, and the physician's assessment of the history and skin testing to determine which antigens to use, in which concentrations, and in what volumes. These codes include CPT code 95144 (single dose vials) and CPT code 95165 (multiple dose vials). However, for stinging insect venoms, the extract/extract preparation codes are the following:

- CPT code 95145, multiple dose vials for single venom.
- CPT code 95146, multiple dose vials for two venoms.
- CPT code 95147, multiple dose vials for three venoms.
- CPT code 95148, multiple dose vials for four venoms.
- CPT code 95149, multiple dose vials for five venoms.

Also, a final extract/extract preparation CPT code is 95170 (multiple dose vials of whole body extract of biting insect or other arthropod). For all of these codes, the biller is required to specify the number of doses for which he or she is billing. For the venom extracts, if a code represents more than one venom, when there is one dose of each venom furnished, that constitutes one overall dose for the code. In other words, in order for there to be one dose of a multiple venom code, there has to be one dose of *each* of the venoms.

The third type of antigen code is the complete service code. These codes include the injection as well as the extract and the extract preparation. The complete service codes include:

- CPT code 95120, single injection, including extract. This code is equivalent to CPT code 95115 plus CPT code 95165 (one dose).
- CPT code 95125, multiple injections, including extract. This code is equivalent to CPT code 95117 plus CPT code 95165 (two doses). We have been advised that the complete CPT codes (95120 and 95125) never equal the single dose vial CPT code 95144 plus CPT code 95115 or CPT code 95117 because there are virtually no circumstances when an allergist who is administering an injection should be doing so from a single dose vial. Supposedly, all allergists administering the shots themselves do so from multiple dose vials. They mix and furnish single dose vials only for administration by some other physician and that other physician would be billing an injection-only code—either CPT code 95115 or 95117.)
- CPT code 95130, injection for single stinging insect venom. This code is equivalent to CPT code 95115 plus CPT code 95145 (one dose of one venom).
- CPT code 95131, injections for two stinging insect venoms. This code is equivalent to CPT code 95117 plus CPT code 95146 (one dose each of two venoms—which is equal to one overall dose of code CPT code 95146).
- CPT code 95132, injections for three stinging insect venoms. This code is equivalent to CPT code 95117 plus CPT code 95147 (one dose each of three venoms—which is equal to one overall dose of CPT code 95147).
- CPT code 95133, injections for four stinging insect venoms. This code is equivalent to CPT code 95117 plus CPT code 95148 (one dose each of four venoms—which is equal to one overall dose of CPT code 95148).
- CPT code 95134, injections for five stinging insect venoms. This code is equivalent to CPT code 95117 plus CPT code 95149 (one dose each of five venoms—which is equal to one overall dose of CPT code 95149).

The first two types of CPT code (that is, injection-only and extract/extract preparation) are frequently used in situations when the allergist who prepares and furnishes the extract does not perform the injection. In many cases, those injections may be furnished by primary care physicians to whom the allergist has sent the extract for a particular patient. In those instances, the injection code is billed by the primary care physician and the extract/extract preparation code is billed by the allergist. About 50 percent of allergists also use these two types of codes in tandem, rather than billing the complete service code. In other words, they bill separately for the two services that they furnish. The complete service codes are billed by the other half of the allergists when they furnish both the injection and the extract.

We are proposing to no longer permit payment under the complete service codes. Although approximately half of the allergists are using these codes, we believe that it is virtually impossible to guarantee accurate payment under them. As has been recommended to us by JCAI, payment for the complete codes should be the same as payment for the equivalent component codes. However, in our judgment, that cannot be accomplished under the "complete" codes. For example, CPT code 95120 is equivalent to CPT code 95115 plus CPT code 95165, one dose. Thus, we would recommend single or constant RVUs for CPT code 95120—equalling one injection and one dose of extract. Presumably, if on the same day an allergist provides a 10-dose vial to a patient and also gives one dose of it in one injection, the allergist could bill either CPT code 95120 and CPT code 95165 (nine doses), or the allergist could bill CPT code 95115 (single injection) plus CPT code 95165 (10 doses). The payment result would be the same, but we believe that the first approach is too complicated and prone to errors on the part of both physicians and Medicare carriers. Similarly, we are not entirely convinced that no allergists furnishing injections would bill for CPT code

95144 (single dose vial of extract). Under our payment system, a complete service code must have a one per dose price. However, that is not possible if more than one option for furnishing the complete service is available and those options have different resource costs. If indeed an allergist does furnish and inject from a single dose vial, then the pricing of the complete service is not easily determined. The price for the complete service could be the sum of the injection plus a dose from a multiple dose vial or the sum of the injection plus a dose from a single dose vial. The permutations of what the complete codes could represent are numerous and, therefore, no single appropriate price could be established. Finally, we believe the terminology of CPT codes 95120 and 95125 is confusing and could lead some nonallergists to bill these codes if they provide allergenic extract furnished by an allergist who has also billed for the extract using CPT code 95144 or CPT code 95165. Therefore, we propose keeping billing and pricing simple by having only component billing and eliminating the use of the complete codes. Commenters recommending retaining the complete codes should address our concerns about establishing one fair price for each complete code (although the code might represent more than one means of delivering the service and those means have different resource costs).

C. Proposed RVUs

We are proposing to accept the RVUs that have been recommended to us by JCAI. The JCAI recommendations include not only RVUs for the antigen codes, but also RVUs for the injection-only codes. The JCAI recommendations for the injection-only codes are slightly less than the 1994 RVUs for those codes. The proposed RVUs are:

CPT Code	Work	Practice expense	Malpractice expense	Total
95115	.....	.37	.02	.39.
95117	.....	.49	.02	.51.
95144	.06/dose ...	.13/dose ...	.01/dose ...	.20/dose.
95165	.06/dose ...	.10/dose ...	.01/dose ...	.17/dose.
95145	.06/dose ...	.34/dose ...	.03/dose ...	.43/dose.
95146	.06/dose ...	.62/dose ...	.03/dose ...	.71/dose.
95147	.06/dose ...	.92/dose ...	.03/dose ...	1.01/dose.
95148	.06/dose ...	.92/dose ...	.03/dose ...	1.01/dose.
95149	.06/dose ...	1.15/dose .	.03/dose ...	1.24/dose.
95170	.06/dose ...	.35/dose ...	.03/dose ...	.44/dose.

D. Budget Neutrality

Section 13518 of OBRA '93 requires that, in 1995, we spend the same for antigens under the fee schedule that we would have spent for them under the current payment system. Because of the variations in the current payment system, it is impossible to implement this budget neutrality requirement. Currently, there is wide variation in the way in which Medicare carriers pay for antigens. Some pay per dose. Some pay on the basis of volume, and still others pay on the basis of volume and concentration. There is no single reliable and uniform unit of service across all carriers. This means, therefore, that we are unable to precisely relate current frequencies to those that would occur under the fee schedule and, in the absence of doing so, we are unable to guarantee budget neutrality within the antigen category. We believe, however, that the allowances being proposed are reasonable, and we have no basis for concluding that they would result in either increased or decreased expenditures compared with the existing system.

Since CPT codes 95115 and 95117 (injection-only) are currently paid under the physician fee schedule and since we propose changes in the allowances for these services, we are subjecting these RVU changes to the overall budget neutrality adjustment for fee schedule changes (that is, the $20 million threshold).

E. Transition

Because of the wide variation in the carriers' current descriptions of antigen services, we are not proposing transition to the full fee schedule. Instead, antigen fee schedule payments would, from the outset, be based on the full fee schedule amount. In our judgment, it is appropriate to transition payments only when the units of service are the same, or at least roughly the same, under the old and new payment systems. In this way, one would be transitioning payments only, not the definitions of the services. Since we have no assurance that most carriers use the antigen definitions to be used under the fee schedule, we propose no transition from those prior carrier payment amounts.

IV. Change in the MVPS Calculation for FY 1996

We propose changing the method for calculating the MVPS for FY 1996 by expanding the medical and other health services in the performance standard to include clinical laboratory tests performed in hospital outpatient settings. Currently, the performance standard includes clinical laboratory services performed in physicians' offices and in independent laboratories.

The MVPS, as defined in the December 29, 1989 notice (54 FR 53819), currently excludes clinical laboratory services furnished in hospital outpatient departments because the hospital cost reports related to these services were not readily available under data collection systems in place at the time. Because we now have the capacity to use this information, and because physicians are responsible for the volume and intensity of tests performed regardless of the setting, we propose to include clinical laboratory services furnished in hospital outpatient departments in the MVPS calculation beginning in FY 1996. The physician fee schedule update would, therefore, be affected by this change beginning CY 1998.

V. Changes to the Regulations

In § 410.152(b)(4), concerning payment under Part B, we would recognize that payment may be based on other payment methodologies (for example, the physician fee schedule) than simply on a reasonable change basis.

In § 414.2 ("Definitions"), we would add the definition of "antigens" under the definition of "physicians' services."

In § 414.4 ("Fee schedule areas"), in paragraph (b), we would add Iowa as an additional statewide fee schedule area.

We would add a new § 414.39 ("Special rules for payment of care plan oversight").

In § 414.314 ("Monthly capitation payment method"), we would revise

paragraph (c) ("Determination of payment amount") to indicate that the MCP is paid under the Medicare physician fee schedule described in part 414. We would also remove paragraph (d) ("Publication of payment amount") of this section because the MCP rate would be published with all other physician services paid under the physician fee schedule.

VI. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*).

VII. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VIII. Regulatory Impact Analysis

A. Regulatory Flexibility Act

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 rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, all physicians are considered to be small entities.

This proposed rule would not have a significant economic impact on a substantial number of small entities. Nevertheless, we are preparing a regulatory flexibility analysis because the provisions of this rule are expected to have varying effects on the distribution of Medicare physician payments across specialties and across geographic areas. We anticipate that virtually all of the approximately 500,000 physicians who furnish covered services to Medicare beneficiaries would be affected by one or more provisions of this rule. In addition, physicians who are paid by private insurers for non-Medicare services would be affected to the extent that they are paid by private insurers that choose to use the proposed RVUs. However, with few exceptions, we expect that the impact would be limited.

If these proposals result in increases in Medicare payment amounts, beneficiary liability would also increase because the coinsurance amounts would increase. In addition, if nonparticipating physicians do not accept assignment, the amount that they may bill above the fee schedule amount would also increase because the limiting charge for the service would increase. If a proposal results in a decrease in Medicare payment amounts or the bundling of payment for one service into payment for another, beneficiary liability would decrease.

With respect to the proposal to include the MCP under the Medicare physician fee schedule, we are unable to estimate the impact at this time because we are not proposing RVUs for the service.

Section 1848(c)(2)(B) of the Act requires that adjustments to RVUs in a year may not cause the amount of expenditures for the year to differ by more than $20 million from the amount of expenditures that would have been made if these adjustments had not been made. If this threshold is exceeded, we make adjustments to the RVUs in order to preserve budget neutrality. The proposals discussed in sections B through F below would have no impact on total Medicare expenditures because the effects of these changes would be neutralized in the establishment of RVUs for 1995.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

B. Effects of Implementing Proposed Changes to GPCIs

The revised GPCIs would be implemented in a budget-neutral manner. They would not change the total national physician fee schedule payments that would have been made in 1995 had the current GPCIs been retained. The revised GPCIs would merely redistribute payments among fee schedule payment areas. The general geographic effects of this redistribution are set forth in Addendum D.

The overall effect of the GPCI changes cannot be estimated by summing the effects of the work, practice expense, and malpractice changes. Merely summing the changes would result in an incorrect increase or decrease. The effects are not additive because each of the three GPCI components have different weights. A complete discussion, with examples, of the revised GPCIs can be found in section II.A.3. of this proposed rule.

Again, we stress that the GPCIs measure relative cost differences among areas compared to the national average. The national average cost is represented by a value of about 1.0. (It is not exactly 1.0 because of budget-neutrality rescaling.) A revised GPCI showing a decrease from the current value does not necessarily mean that absolute costs of an individual physician or absolute costs in an area have decreased. Rather, it means that costs in that area have decreased compared to national average costs. In other words, national average costs increased more than did area costs.

C. Payment Area (Locality) Changes

The change to convert Iowa to a statewide payment area effective January 1, 1995, would be made on a budget-neutral basis within the State. However, some modest redistribution in payments could occur within the State. From our past experience, redistribution of payments would flow from urban areas, which usually have had higher GPCIs before the change, to rural areas, which usually have had lower GPCIs before the change. We estimate this redistribution to be generally in the range of 1 to 3 percent. These estimates represent aggregate effects among the areas of the State. The effect on individual physicians would vary depending on factors such as the mix and volume of their services to Medicare beneficiaries.

D. Effects of Proposed Work RVUs for Carrier-Priced and Non-Medicare CPT Codes

We are proposing to create RVUs for 11 CPT codes for services not covered by Medicare and for 60 codes for services that are currently carrier-priced. An example of a service not covered by Medicare is CPT code 92340 (fitting of monofocal spectacles, except for aphakia). In general, the services that are currently carrier-priced are rarely furnished to Medicare beneficiaries. An example of a carrier-priced service is CPT code 99431 (history and examination of the normal newborn infant). This effort would benefit State Medicaid programs and private insurers that base their payment, in whole or in part, on the Medicare physician fee schedule. We are not able to estimate the total national impact of the creation of these RVUs because we do not know the frequency of the use of RVUs by payers other than Medicare. Also, we do not know how third-party payments based on our RVUs would compare to the payments currently made by these payers.

E. Effects of Proposed Payment Policy Revisions

1. Separate Payment for Physician Care Plan Oversight Services

We propose to pay for care plan oversight services for patients receiving HHA services that are covered by Medicare. We propose to establish a fee schedule payment amount based on 1.63 RVUs, which, by applying the nonsurgical CF, results in a monthly payment amount of approximately $54.

Preliminary studies based on HHA utilization data indicate that payment for this service would be allowed for approximately 5.25 million claims per year and would result in increased Medicare expenditures of approximately $210 million for 1995. Thus, we estimate that a reduction of approximately 0.7 percent in the RVUs for other services would be required to offset this amount to retain budget neutrality. We would consider this adjustment to be "interim" for three years, during which time we would monitor utilization of this service. If utilization is significantly higher than our estimate, we would make an additional adjustment to achieve budget neutrality.

If we implement this policy, beneficiaries overall would not sustain any change in coinsurance amounts or out-of-pocket costs. Because we are making this a budget-neutral change, we would therefore be reducing the allowed fee for all other physician services in order to pay for care plan oversight. We estimate that the average HHA beneficiary would be liable for approximately $16 in coinsurance for care plan oversight services each year. Since an estimated 75 percent of beneficiaries have either Medigap policies or Medicaid coverage for the coinsurance amounts, only a limited number of beneficiaries would see any financial impact due to this change. Approximately 10 percent of beneficiaries receive services from nonparticipating physicians. These beneficiaries would be liable for any amount that exceeds the Medicare-approved amount up to the limiting charge for this service. We believe the additional monthly amount because of the limiting charge provision would be approximately $8. Any impact on physicians who do not furnish this service would result from our reducing the RVUs for other physician services to achieve budget neutrality.

2. Payment for Multiple Surgical Procedures

We propose to revise our method of payment for multiple surgical procedures performed on the same patient on the same day by the same physician. We currently have three different sets of multiple surgery rules. We are not proposing to change the dermatology or endoscopy multiple surgery rules. We are proposing to revise only the standard multiple surgery rule that currently requires carriers to rank the procedures by payment amount and base payment on the highest priced procedure at the lesser of actual charges or 100 percent of the fee schedule amount; the second procedure at 50 percent; the third, fourth, and fifth procedures at 25 percent; and procedures subsequent to the fifth procedure "by report" based on documentation of the services furnished.

We propose to revise the current standard multiple surgery policy to base payment to physicians on the lesser of actual charges or 100 percent for the highest priced procedure, and the lesser of actual charges or 50 percent for the second through fifth procedures. Procedures performed subsequent to the fifth procedure would continue to be paid "by report" based on documentation of the services furnished. Under this proposed change, the standard multiple surgery policy would be the same as the current policy that applies to multiple dermatology procedures. This change in payment policy would simplify carrier payment procedures because we would have two, rather than three, multiple surgery policies.

Preliminary studies of 1992 utilization and cost data indicate that this change to the 100/50/50/50/50 percent payment policy would result in increased Medicare payments of approximately $37 million, were it not for the budget-neutrality adjustment to all RVUs that we would make if we implement this change. Our preliminary estimate is that this change would require a reduction in all RVUs of about 0.1 percent. This estimate may change in the final rule based on a review of 1993 utilization and the level of the updates for 1995.

If we implement this proposal, beneficiary liability would increase because the coinsurance for the third through fifth services would increase. This would occur because physicians who perform multiple procedures that are now paid on the basis of the lesser of the actual charge or 25 percent of the fee schedule payment for the third through fifth procedures would be paid twice as much for the third through fifth procedures performed on the same day for a patient, and the coinsurance is a fixed percent of the amount Medicare pays. In addition, the amount that nonparticipating physicians may bill over the fee schedule amount if they do not accept assignment would also increase because the limiting charge is a percent of the fee schedule amount. However, beneficiary liability may be reduced slightly in the aggregate as a result of slightly lower payments for other services.

Physicians who do not perform the surgical procedures to which this policy applies may have the RVUs for the services they perform slightly reduced as a result of this policy change.

3. Application of Site-of-Service Payment Differential

We propose to revise the current list of surgical procedures subject to the site-of-service limitation using 1993 data. The revised list would be effective for services furnished beginning January 1, 1995. To avoid any concern about the statistical validity of the data for low volume procedures, we would exclude any procedure performed less than 100 times a year unless the procedure is part of a "family" of codes that meets the requirements to be on the site-of-service list. We are proposing to add approximately 230 codes and remove 8 codes from the site-of-service list based on 1993 data and criteria. Were it not for budget-neutrality adjustments, we estimate that these additions would result in an $11.9 million reduction in Medicare payments.

4. Bundled Services

The proposed bundling of the following services would mean that physicians who are currently billing for and receiving separate payment for the services would no longer do so.

a. *Generation and interpretation of automated data (CPT codes 78890 and 78891).* These two codes should be billed in addition to the primary procedure, but in CY 1992, CPT codes 78890 and 78891 were billed in combination with another procedure only 12.7 and 2.5 percent of the time, respectively. The data indicate that these codes are being reported incorrectly. We would implement the proposal to bundle these codes into the codes for the primary procedure in a budget-neutral manner by redistributing the RVUs currently assigned to CPT codes 78890 and 78891 across all codes. The expenditure for these services in CY 1992 was $1.6 million for approximately 38,000 services. The effect of this change on individual physicians would be minimal.

b. *Noninvasive ear or pulse oximetry (CPT code 94760).* We propose that payment for this procedure be

considered bundled into the RVUs of the procedure requiring the pulse oximetry testing. We would implement this proposal in a budget-neutral manner by redistributing the 0.27 RVUs currently assigned to CPT code 94760 across all services. The expenditure for this procedure in CY 1992 was $5.3 million for 4 million services. Since both the RVUs and the current frequency for code 94760 are small, any effect of redistributing the RVUs over all services would be minimal.

5. RVUs for Doppler Echocardiography (CPT Code 93325)

We are proposing to redistribute the RVUs assigned to CPT code 93325 (Doppler color flow velocity mapping). This procedure was originally classified as a TC service only, without a PC. As a result of the refinement process for 1993, we established a PC for the procedure primarily at the expense of the TC. While physicians and other entities billing for the complete or global services were unaffected by this change, physiological laboratories billing the TC saw their payments reduced by more than one-half.

If adopted, this proposed rule would approximately double the fee schedule payment amount for the TC of CPT code 93325 when the service is furnished in nonhospital settings. Payment for the PC of the procedure in settings such as hospitals, in which the PC only is billed, would be reduced by over 90 percent. Global payments for procedures furnished in physicians' offices and other nonhospital settings would be unaffected by adoption of this proposed rule.

6. Nuclear Medicine

It is our understanding that many carriers currently do not pay for the second procedure of certain nuclear medicine multiple diagnostic procedures. However, we believe that patients with certain malignancies may require multiple nuclear medicine diagnostic procedures. Under this proposal, carriers would pay the full fee schedule payment for the procedure with the highest payment and 50 percent for the second procedure. We believe that the overall effect of this proposal would be minimal. If there are carriers that currently pay in full for the second procedure, payments for these services would be reduced. Further, there would be a slight increase in payments by carriers that currently do not pay for the second procedure.

7. ESRD—Hospital Inpatient Dialysis on the Same Day as an Evaluation and Management Service

We consider physician dialysis services to be an evaluation and management service and believe dialysis should be treated similarly to all other evaluation and management services. Therefore, we propose to pay for either an evaluation and management code or a physician dialysis code, but not both, when furnished on the same day. According to CY 1992 data, evaluation and management services were furnished on the same day as dialysis services approximately 263,500 times and allowed amounts for these services approximated $9.5 million. Our proposal would be implemented in a budget-neutral manner because the RVUs for the evaluation and management codes would be redistributed across the four dialysis codes. This change would increase payments for the four dialysis services.

8. Services Considered To Be Medicare Part A Services

Therapeutic apheresis (CPT code 36520) is currently performed in the office setting 5.39 percent of the time, in the inpatient hospital setting 62.09 percent of the time, and in the outpatient hospital setting 30.47 percent of the time. In 1992, total expenditures for therapeutic apheresis in these settings were $1,904,036. By designating this service as an "incident-to" service and allowing payment only when the service is performed in the office setting, we estimate that an additional $1.8 million would be saved. These savings would be included in the budget neutrality calculations and, thus, redistributed among the other services under the fee schedule. We do not anticipate that this proposal would have an impact on hospitals.

F. Effects of Payment for Antigens (Allergen Immunotherapy)

Effective for services furnished beginning January 1, 1995, we are proposing to eliminate the use of HCPCS antigen J codes and require all physicians to bill for allergy therapy services using the CPT codes described in detail in section III of this preamble. We are also proposing to no longer permit payment under the CPT allergy complete service codes that are used by approximately half of the allergists.

Because of the variations in the current payment system, we are unable to precisely relate current frequencies to those that would occur under the fee schedule. Therefore, we are unable to ensure budget neutrality within the antigen category. We believe, however, that the allowances being proposed are reasonable and we have no basis for concluding that the RVUs would result in a significant change in expenditures compared with the existing system.

G. Change in the MVPS Calculation for FY 1996

We believe that clinical laboratory services performed in hospital outpatient settings should be included in the MVPS beginning in FY 1996. Under present law, these services would be included in the "other nonsurgical" MVPS category. This proposal would affect the update beginning in CY 1998, which is based on the 1996 MVPS. Based on current assumptions, this change would result in estimated savings of $25 million in FY 1998, $75 million in FY 1999, and $125 million in FY 2000.

H. 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 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

This proposed rule would have little direct effect on payments to rural hospitals since this rule would change only payments made to physicians and certain other practitioners under Part B of the Medicare program and would make no change in payments to hospitals under Part A. We do not believe the changes would have a major, indirect effect on rural hospitals.

Therefore, we are not preparing an analysis for section 1102(b) of the Act since we have determined, and the Secretary certifies, that this rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Medicare, Physicians, Reporting and recordkeeping requirements.

42 CFR chapter IV would be amended as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

A. Part 410 is amended as set forth below:

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102, 1832, 1833, 1834, 1835, 1861(r), (s), (aa), (cc), and (ff), 1871, and 1881 of the Social Security Act (42 U.S.C. 1302, 1395k, 13951, 1395m, 1395n, 1395x(r), (s), (aa), (cc), and (ff), 1395hh, and 1395rr).

Subpart E—Payment of SMI Benefits

2. In § 410.152, the introductory text of paragraph (b) is republished and paragraph (b)(4) is revised to read as follows:

§ 410.152 Amounts of payment.

* * * * *

(b) *Basic rules for payment.* Except as specified in paragraphs (c) through (h) of this section, Medicare Part B pays the following amounts:

* * * * *

(4) For services furnished by a person or an entity other than those specified in paragraphs (b)(1) through (b)(3) of this section, 80 percent of the reasonable charges or other payment basis for the services.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

B. Part 414 is amended as set forth below:

Subpart A—General Provisions

1. The authority citation for part 414, subpart A continues to read as follows:

Authority: 1102, 1832, 1833, 1834, 1842, 1848, 1861(b) and (s), 1862, 1866, 1871, and 1881 of the Social Security Act as amended (42 U.S.C. 1302, 1395k, 13951, 1395m, 1395u, 1395w-4, 1395x(b) and (s), 1395y, 1395cc, 1395hh, and 1395rr).

2. In § 414.2, in the definition of *"Physicians' services"*, a new paragraph (6) is added to read as follows:

§ 414.2 Definitions.

* * * * *

Physicians' services * * *

(6) Antigens, as described in section 1861(s)(2)(G) of the Act.

* * * * *

3. In § 414.4, paragraph (b) is revised to read as follows:

§ 414.4 Fee schedule areas.

* * * * *

(b) *Statewide areas.* HCFA recognizes statewide fee schedule areas for Iowa, Minnesota, Nebraska, North Carolina, Ohio, and Oklahoma.

* * * * *

4. A new § 414.39 is added to read as follows:

§ 414.39 Special rules for payment of care plan oversight.

(a) *General.* Except as specified in paragraph (b) of this section, payment for care plan oversight is included in payment for visits and other services under the physician fee schedule.

(b) *Exception.* Separate payment is made under the following conditions for beneficiaries who receive HHA services that are covered by Medicare:

(1) The care plan oversight services require recurrent physician supervision of therapy involving 30 or more minutes of the physician's time in a 30-day period.

(2) Only one physician per patient may receive payment for a 30-day period. The physician must have furnished a service requiring a face-to-face encounter with the patient at least once during the 6-month period before the month for which care plan oversight payment is first billed. The physician may not have a significant financial or contractual relationship with an HHA in accordance with § 424.22(d).

(3) Payment for care plan oversight during a global period of a surgery is made when the care plan oversight is documented to be unrelated to the surgery.

5. In § 414.314, paragraph (d) is removed and paragraph (c) is revised to read as follows:

§ 414.314 Monthly capitation payment method.

* * * * *

(c) *Determination of payment amount.* The MCP is paid under the Medicare physician fee schedule described in this part 414.

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

Dated: May 31, 1994.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: June 15, 1994.

Donna E. Shalala,

Secretary.

Note: The following addenda will not appear in the annual Code of Federal Regulations.

ADDENDUM A—1994 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier No.	Locality No.	Locality Name	Work	Practice expense	Malpractice
510	5	Birmingham, AL	0.981	0.913	0.824
510	4	Mobile, AL	0.964	0.911	0.824
510	2	North Central AL	0.970	0.867	0.824
510	1	Northwest AL	0.985	0.869	0.824
510	6	Rest of AL	0.975	0.851	0.824
510	3	Southeast AL	0.972	0.869	0.824
1020	1	Alaska	1.106	1.255	1.042
1030	5	Flagstaff (city), AZ	0.983	0.911	1.255
1030	1	Phoenix, AZ	1.003	1.016	1.255
1030	7	Prescott (city), AZ	0.983	0.911	1.255
1030	99	Rest of Arizona	0.987	0.943	1.255
1030	2	Tucson (city), AZ	0.987	0.989	1.255
1030	8	Yuma (city), AZ	0.983	0.911	1.255
520	13	Arkansas	0.960	0.856	0.302
2050	26	Anaheim-Santa Ana, CA	1.046	1.220	1.370
542	14	Bakersfield, CA	1.028	1.050	1.370
542	11	Fresno/Madera, CA	1.006	1.009	1.370
542	13	Kings/Tulare, CA	0.999	1.001	1.370
2050	18	Los Angeles, CA (1st of 8)	1.060	1.196	1.370
2050	19	Los Angeles, CA (2nd of 8)	1.060	1.196	1.370

ADDENDUM A—1994 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality Name	Work	Practice expense	Malpractice
2050	20	Los Angeles, CA (3rd of 8)	1.060	1.196	1.370
2050	21	Los Angeles, CA (4th of 8)	1.060	1.196	1.370
2050	22	Los Angeles, CA (5th of 8)	1.060	1.196	1.370
2050	23	Los Angeles, CA (6th of 8)	1.060	1.196	1.370
2050	24	Los Angeles, CA (7th of 8)	1.060	1.196	1.370
2050	25	Los Angeles, CA (8th of 8)	1.060	1.196	1.370
542	3	Marin/Napa/Solano, CA	1.012	1.198	1.370
542	10	Merced/surr. cntys, CA	1.018	1.009	1.370
542	12	Monterey/Santa Cruz, CA	1.023	1.108	1.370
542	1	N. coastal cntys, CA	1.003	1.072	1.370
542	2	NE rural CA	1.001	0.990	1.370
542	7	Oakland-Berkeley, CA	1.028	1.258	1.370
542	27	Riverside, CA	1.026	1.080	1.370
542	4	Sacramento/surr. cntys, CA	1.026	1.088	1.370
542	15	San Bernardino/E. cntrl CA	1.025	1.077	1.370
2050	28	San Diego/Imperial, CA	1.026	1.090	1.370
542	5	San Francisco, CA	1.038	1.303	1.370
542	6	San Mateo, CA	1.038	1.303	1.370
2050	16	Santa Barbara, CA	1.012	1.073	1.370
542	9	Santa Clara, CA	1.048	1.286	1.370
542	8	Stockton/surr. cntys, CA	1.019	1.027	1.370
2050	17	Ventura, CA	1.034	1.132	1.370
550	1	Colorado	0.999	0.988	0.683
10230	4	Eastern CT	0.999	1.053	1.036
10230	1	NW and N. central CT	1.002	1.071	1.025
10230	3	South central CT	1.018	1.103	1.188
10230	2	SW CT	1.053	1.139	1.231
570	1	Delaware	1.026	1.018	0.664
580	1	DC + MD/VA suburbs	1.059	1.168	0.947
590	3	Fort Lauderdale, FL	0.993	0.981	1.376
590	4	Miami, FL	1.034	1.025	1.641
590	2	N/NC Florida cities	0.975	0.932	1.108
590	1	Rest of Florida	0.966	0.871	1.108
1040	1	Atlanta, GA	0.975	1.022	0.752
1040	4	Rest of Georgia	0.956	0.841	0.752
1040	2	Small GA cities 02	0.962	0.895	0.752
1040	3	Small GA cities 03	0.961	0.869	0.752
1120	1	Hawaii	1.003	1.094	1.025
5130	12	North Idaho	0.965	0.917	0.889
5130	11	South Idaho	0.967	0.936	0.889
621	10	Champaign-Urbana, IL	0.965	0.920	1.137
621	16	Chicago, IL	1.044	1.114	1.773
621	3	De Kalb, IL	0.978	0.925	1.137
621	11	Decatur, IL	0.981	0.927	1.137
621	12	East St. Louis, IL	0.989	0.958	1.579
621	6	Kankakee, IL	0.972	0.925	1.137
621	8	Normal, IL	0.997	0.968	1.137
621	1	Northwest, IL	0.974	0.896	1.137
621	5	Peoria, IL	1.009	1.031	1.137
621	7	Quincy, IL	0.974	0.896	1.137
621	4	Rock Island, IL	0.995	0.958	1.137
621	2	Rockford, IL	1.010	1.018	1.137
621	13	Southeast IL	0.974	0.896	1.137
621	14	Southern IL	0.974	0.896	1.137
621	9	Springfield, IL	0.996	0.966	1.137
621	15	Suburban Chicago, IL	1.020	1.097	1.137
630	1	Metropolitan Indiana	0.998	0.963	0.547
630	3	Rest of Indiana	0.979	0.896	0.516
630	2	Urban Indiana	0.980	0.905	0.516
640	5	Des Moines (Polk/Warren), IA	0.997	0.966	0.666
640	3	North Central Iowa	0.971	0.916	0.666
640	2	Northeast Iowa	0.972	0.918	0.666
640	6	Northwest Iowa	0.969	0.890	0.666
640	4	S. cen. IA (excl Des Moines)	0.962	0.881	0.666
640	1	SE Iowa (incl Iowa City)	0.976	0.933	0.666
640	7	Southwest Iowa	0.968	0.900	0.666
740	5	Kansas City, KS	0.978	0.964	1.134
650	1	Rest of Kansas	0.953	0.893	1.134
740	4	Suburban Kansas City, KS	0.978	0.964	1.134
660	1	Lexington & Louisville, KY	0.984	0.917	0.667
660	3	Rest of Kentucky	0.974	0.875	0.667

ADDENDUM A—1994 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality Name	Work	Practice expense	Malpractice
660	2	Sm cities (city limits) KY	0.976	0.898	0.667
528	7	Alexandria, LA	0.985	0.889	0.808
528	3	Baton Rouge, LA	0.991	0.966	0.808
528	6	Lafayette, LA	0.982	0.928	0.808
528	4	Lake Charles, LA	0.975	0.907	0.808
528	5	Monroe, LA	0.979	0.880	0.808
528	1	New Orleans, LA	0.994	1.003	1.185
528	50	Rest of Louisiana	0.972	0.880	0.824
528	2	Shreveport, LA	1.003	0.940	0.808
21200	2	Central Maine	0.942	0.903	0.716
21200	1	Northern Maine	0.947	0.912	0.716
21200	3	Southern Maine	0.956	0.980	0.716
690	1	Baltimore/surr. cntys, MD	1.027	1.040	0.927
690	3	South + E. shore MD	1.011	1.010	0.820
690	2	Western Maryland	1.006	1.013	0.843
700	2	Mass. suburbs/rural (cities)	0.997	1.072	0.855
700	1	Massachusetts urban	1.002	1.131	0.855
710	1	Detroit, MI	1.059	1.091	1.736
710	2	Michigan, not Detroit	1.010	0.971	1.196
720	00	Minnesota (blue shield)	0.999	0.971	0.748
10240	00	Minnesota (travelers)	0.999	0.971	0.748
10250	1	Rest of Mississippi	0.960	0.838	0.650
10250	2	Urban MS (city limits)	0.966	0.902	0.650
740	3	K.C. (Jackson county), MO	0.978	0.964	1.179
740	2	N. K.C. (Clay/Platte), MO	0.978	0.964	1.179
11260	3	Rest of MO	0.950	0.847	1.179
740	6	Rural NW counties, MO	0.953	0.866	1.179
11260	2	Sm. E. cities, MO	0.954	0.838	1.179
740	1	St. Joseph, MO	0.950	0.867	1.179
11260	1	St. Louis/lg. E. cities, MO	0.988	0.964	1.352
751	1	Montana	0.967	0.926	0.718
655	00	Nebraska	0.960	0.883	0.435
1290	3	Elko & Ely (cities), NV	0.984	1.026	1.144
1290	1	Las Vegas, et al (cities), NV	1.036	1.082	1.144
1290	2	Reno, et al (cities), NV	1.008	1.141	1.144
1290	99	Rest of Nevada	1.020	1.079	1.144
780	40	New Hampshire	0.962	1.011	0.602
860	2	Middle New Jersey	1.034	1.070	1.153
860	1	Northern New Jersey	1.040	1.131	1.153
860	3	Southern New Jersey	1.016	1.030	1.153
1360	5	New Mexico	0.981	0.925	0.767
801	1	Buffalo/surr. cntys, NY	1.006	0.942	0.963
803	1	Manhattan, NY	1.059	1.255	1.647
801	3	N. central cities, NY	0.997	0.952	0.963
803	2	NYC suburbs/Long Is., NY	1.060	1.229	1.929
803	3	Poughkpsie/N. NYC suburbs	1.004	1.018	1.325
14330	4	Queens, NY	1.059	1.255	1.861
801	2	Rochester/surr. cntys, NY	1.021	1.017	0.963
801	4	Rest of New York	0.988	0.935	0.963
5535	00	North Carolina	0.968	0.902	0.378
820	1	North Dakota	0.965	0.895	0.688
16360	00	Ohio	0.993	0.951	0.920
1370	00	Oklahoma	0.969	0.911	0.516
1380	2	Eugene, et al (cities), OR	0.968	1.008	0.951
1380	1	Portland, et al (cities), OR	0.993	1.033	0.951
1380	99	Rest of Oregon	0.979	0.997	0.951
1380	3	Salem, et al (cities), OR	0.974	0.990	0.951
1380	12	SW OR. cities (city limits)	0.974	0.988	0.951
865	2	Lg. Pennsylvania cities	1.008	1.001	1.440
865	1	Philly/Pitt med schs/hosps	1.014	1.014	1.552
865	4	Rest of Pennsylvania	0.975	0.929	0.986
865	3	Small Pennsylvania cities	0.984	0.945	0.986
973	20	Puerto Rico	0.882	0.763	0.466
870	1	Rhode Island	1.009	0.998	0.734
880	1	South Carolina	0.971	0.874	0.448
820	2	South Dakota	0.951	0.857	0.688
5440	35	Tennessee	0.969	0.896	0.407
900	29	Abilene, TX	0.971	0.888	0.504
900	26	Amarillo, TX	0.972	0.900	0.504
900	31	Austin, TX	0.969	0.968	0.504
900	20	Beaumont, TX	0.998	0.955	0.504

ADDENDUM A—1994 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality Name	Work	Practice expense	Malpractice
900	9	Brazoria, TX	1.025	0.955	0.504
900	10	Brownsville, TX	0.980	0.888	0.504
900	24	Corpus Christi, TX	0.976	0.944	0.504
900	11	Dallas, TX	0.996	0.971	0.504
900	12	Denton, TX	0.996	0.971	0.504
900	14	El Paso, TX	0.995	0.894	0.504
900	28	Fort Worth, TX	0.973	0.936	0.504
900	15	Galveston, TX	0.982	0.968	0.504
900	16	Grayson, TX	0.964	0.903	0.504
900	18	Houston, TX	1.014	0.982	0.656
900	33	Laredo, TX	0.968	0.856	0.504
900	17	Longview, TX	0.968	0.929	0.504
900	21	Lubbock, TX	0.950	0.881	0.504
900	19	McAllen, TX	0.945	0.873	0.504
900	23	Midland, TX	1.023	0.998	0.504
900	2	Northeast rural Texas	0.968	0.883	0.504
900	13	Odessa, TX	1.008	0.971	0.504
900	25	Orange, TX	0.998	0.955	0.504
900	30	San Angelo, TX	0.954	0.902	0.504
900	7	San Antonio, TX	0.973	0.929	0.504
900	3	Southeast rural Texas	0.973	0.895	0.504
900	6	Temple, TX	0.969	0.886	0.504
900	8	Texarkana, TX	0.953	0.883	0.504
900	27	Tyler, TX	0.984	0.931	0.504
900	32	Victoria, TX	0.976	0.973	0.504
900	22	Waco, TX	0.981	0.871	0.504
900	4	Western rural Texas	0.961	0.852	0.504
900	34	Wichita Falls, TX	0.969	0.896	0.504
910	9	Utah	0.993	0.952	0.739
780	50	Vermont	0.942	0.941	0.533
10490	1	Richmond + Charlottesvl, VA	0.975	0.953	0.462
10490	4	Rest of Virginia	0.967	0.888	0.522
10490	3	Sm. town/industrial VA	0.971	0.892	0.531
10490	2	Tidewater + n. VA counties	0.989	0.994	0.703
973	50	Virgin Islands	1.000	1.000	1.000
1390	2	Seattle (King cnty), WA	1.019	1.049	1.064
1390	3	Spokane + Richlnd (cities), WA	0.996	0.995	1.064
1390	1	W + SE WA (excl Seattle)	1.008	0.992	1.064
16510	16	Charleston, WV	0.987	0.962	0.688
16510	18	Eastern valley, WV	0.962	0.881	0.688
16510	19	Ohio River valley, WV	0.962	0.881	0.688
16510	20	Southern valley, WV	0.960	0.876	0.688
16510	17	Wheeling, WV	0.975	0.900	0.688
951	13	Central Wisconsin	0.960	0.888	0.762
951	40	Green Bay, WI (northeast)	0.979	0.913	0.762
951	54	Janesville, WI (s-central)	0.970	0.905	0.762
951	19	La Crosse, WI (w-central)	0.976	0.919	0.762
951	15	Madison, WI (Dane county)	0.977	0.979	0.762
951	46	Milwaukee suburbs, WI (SE)	1.010	1.008	0.762
951	4	Milwaukee, WI	1.008	1.009	0.762
951	12	Northwest Wisconsin	0.966	0.898	0.762
951	60	Oshkosh, WI (E-central)	0.974	0.911	0.762
951	14	Southwest Wisconsin	0.960	0.888	0.762
951	36	Wausau, WI (N-central)	0.971	0.898	0.762
825	21	Wyoming	0.988	0.938	0.641

Note: Work GPCI is the ¼ work GPCI required by Section 1848(e)(1)(A)(iii) of the Social Security Act.

ADDENDUM B—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier No.	Locality No.	Locality name	Work	Practice expense	Malpractice
00510	05	Birmingham, AL	0.994	0.912	0.927
00510	04	Mobile, AL	0.975	0.858	0.927
00510	02	North Central AL	0.973	0.850	0.927
00510	01	Northwest AL	0.990	0.873	0.927
00510	06	Rest Of AL	0.964	0.818	0.927
00510	03	Southeast AL	0.970	0.858	0.927
01020	01	Alaska	1.064	1.155	1.617
01030	05	Flagstaff, AZ	0.971	0.936	1.321

ADDENDUM B—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality name	Work	Practice expense	Malpractice
01030	01	Phoenix, AZ	1.004	0.963	1.321
01030	07	Prescott, AZ	0.971	0.912	1.321
01030	99	Rest Of AZ	0.989	0.948	1.321
01030	02	Tucson, AZ	0.978	0.942	1.321
01030	08	Yuma, AZ	0.984	0.925	1.321
00520	13	Arkansas	0.954	0.853	0.427
02050	26	Anaheim/Santa Ana, CA	1.037	1.205	0.752
00542	14	Bakersfield, CA	1.023	0.992	0.686
00542	11	Fresno/Madera, CA	1.000	0.977	0.596
00542	13	Kings/Tulare, CA	0.987	0.954	0.596
02050	18	Los Angeles (1St Of 8)	1.056	1.207	0.752
02050	19	Los Angeles (2Nd Of 8)	1.056	1.207	0.752
02050	20	Los Angeles (3Rd Of 8)	1.056	1.207	0.752
02050	21	Los Angeles (4Th Of 8)	1.056	1.207	0.752
02050	22	Los Angeles (5Th Of 8)	1.056	1.207	0.752
02050	23	Los Angeles (6Th Of 8)	1.056	1.207	0.752
02050	24	Los Angeles (7Th Of 8)	1.056	1.207	0.752
02050	25	Los Angeles (8Th Of 8)	1.056	1.207	0.752
00542	03	Marin/Napa/Solano, CA	1.015	1.180	0.596
00542	10	Merced/Surr.Cntys, CA	1.002	0.988	0.596
00542	12	Monterey/Santa Cruz, CA	1.008	1.143	0.596
00542	01	N. Coastal Cntys, CA	1.003	1.090	0.596
00542	02	Ne Rural, CA	0.982	0.953	0.596
00542	07	Oakland/Berkley, CA	1.042	1.215	0.596
00542	27	Riverside, CA	1.011	1.059	0.667
00542	04	Sacramento/Surr. Cntys, CA	1.020	1.069	0.596
00542	15	San Bernadino/E.Ctrl Cntys CA	1.015	1.056	0.749
02050	28	San Diego/Imperial, CA	1.017	1.077	0.618
00542	05	San Francisco, CA	1.068	1.330	0.596
00542	06	San Mateo, CA	1.049	1.300	0.596
02050	16	Santa Barbara, CA	1.016	1.119	0.686
00542	09	Santa Clara, CA	1.064	1.289	0.596
00542	08	Stockton/Surr. Cntys, CA	1.001	1.041	0.596
02050	17	Ventura, CA	1.028	1.192	0.686
00550	01	Colorado	0.989	0.951	0.827
10230	04	Eastern CT	1.033	1.132	1.001
10230	01	Nw And N. Cntrl CT	1.049	1.159	1.001
10230	03	S. Cntrl CT	1.056	1.226	1.001
10230	02	Sw CT	1.055	1.275	1.001
00570	01	Delaware	1.021	1.032	0.792
00580	01	DC+MD/VA Suburbs	1.051	1.192	0.980
00590	03	Fort Lauderdale, FL	0.998	1.036	1.867
00590	04	Miami, FL	1.016	1.087	2.456
00590	02	N/Nc FL Cities	0.978	0.952	1.417
00590	01	Rest Of Florida	0.971	0.914	1.417
01040	01	Atlanta, GA	1.007	1.030	0.902
01040	04	Rest Of GA	0.965	0.856	0.902
01040	02	Small GA Cities 02	0.981	0.917	0.902
01040	03	Small GA Cities 03	0.966	0.884	0.902
01120	01	Hawaii/Guam	0.999	1.220	0.921
05130	12	North Idaho	0.957	0.864	0.588
05130	11	South Idaho	0.963	0.887	0.588
00621	10	Champaign-Urbana, IL	0.952	0.884	1.008
00621	16	Chicago, IL	1.028	1.080	1.382
00621	03	De Kalb, IL	0.953	0.873	0.780
00621	11	Decatur, IL	0.962	0.864	0.880
00621	12	East St. Louis, IL	0.988	0.929	1.202
00621	06	Kankakee, IL	0.959	0.881	0.901
00621	08	Normal, IL	0.969	0.893	0.731
00621	01	Northwest, IL	0.951	0.842	0.731
00621	05	Peoria, IL	0.980	0.906	0.731
00621	07	Quincy, IL	0.946	0.824	0.731
00621	04	Rock Island, IL	0.972	0.858	0.731
00621	02	Rockford, IL	0.978	0.941	0.813
00621	13	Southeast IL	0.946	0.814	0.731
00621	14	Southern IL	0.946	0.822	0.822
00621	09	Springfield, IL	0.981	0.936	0.946
00621	15	Suburban Chicago, IL	1.007	1.093	1.159
00630	01	Metropolitan IN	0.989	0.937	0.363
00630	03	Rest Of IN	0.973	0.872	0.346
00630	02	Urban IN	0.974	0.896	0.346

ADDENDUM B—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality name	Work	Practice expense	Malpractice
00640	05	Des Moines (Polk/Warren), IA	0.980	0.941	0.679
00640	03	North Central Iowa	0.956	0.845	0.679
00640	02	Northeast Iowa	0.964	0.873	0.679
00640	06	Northwest Iowa	0.947	0.846	0.679
00640	04	S Cntrl Ia (Excl. Des Moines)	0.941	0.837	0.679
00640	01	Southeast Iowa	0.963	0.892	0.679
00640	07	Southwest Iowa	0.953	0.860	0.679
00740	05	Kansas City, Kansas	0.989	0.949	1.191
00650	01	Rest Of Kansas	0.958	0.877	1.191
00740	04	Suburban Kansas City, Kansas	0.989	0.949	1.191
00660	01	Lexington & Louisville, KY	0.989	0.904	0.819
00660	03	Rest Of Kentucky	0.957	0.821	0.819
00660	02	Sm Cities (City Limits) KY	0.960	0.850	0.819
00528	07	Alexandria, LA	0.958	0.864	0.911
00528	03	Baton Rouge, LA	0.984	0.894	0.911
00528	06	Lafayette, LA	0.971	0.857	0.911
00528	04	Lake Charles, LA	0.974	0.901	0.911
00528	05	Monroe, LA	0.958	0.867	0.911
00528	01	New Orleans, LA	0.999	0.946	0.997
00528	50	Rest Of LA	0.965	0.850	0.913
00528	02	Shreveport, LA	0.971	0.889	0.911
21200	02	Central Maine	0.961	0.929	0.759
21200	01	Northern Maine	0.964	0.920	0.759
21200	03	Southern Maine	0.980	1.034	0.759
00690	01	Baltimore/Surr. Cntys, MD	1.021	1.036	1.115
00690	03	South & E. Shore MD	0.985	0.972	0.862
00690	02	Western MD	0.982	0.930	0.862
00700	02	MA Suburbs/Rural Cities	1.015	1.101	0.978
00700	01	Urban MA	1.030	1.167	0.978
00710	01	Detroit, MI	1.043	1.038	3.051
00710	02	Michigan, Not Detroit	0.998	0.935	1.844
00720	00	Minnesota (Blue Shield)	0.990	0.965	0.594
10240	00	Minnesota (Travelers)	0.990	0.965	0.594
10250	01	Rest Of Mississippi	0.950	0.813	0.726
10250	02	Urban Mississippi	0.964	0.868	0.726
00740	03	K.C. (Jackson Cnty), MO	0.989	0.949	1.207
00740	02	N K.C. (Clay/Platte), MO	0.989	0.949	1.204
11260	03	Rest Of MO	0.944	0.810	1.159
00740	06	Rural Nw Counties, MO	0.950	0.835	1.159
11260	02	Sm E. Cities, MO	0.940	0.809	1.159
00740	01	St Joseph, MO	0.952	0.850	1.159
11260	01	St. Louis/Lg E. Cities, MO	0.983	0.921	1.193
00751	01	Montana	0.952	0.864	0.756
00655	00	Nebraska	0.951	0.872	0.444
01290	03	Elko & Ely (Cities), NV	0.984	0.986	0.887
01290	01	Las Vegas, Et Al. (Cities), NV	1.012	1.022	0.887
01290	02	Reno, Et Al. (Cities), NV	0.997	1.049	0.887
01290	99	Rest Of Nevada	0.997	1.013	0.887
00780	40	New Hampshire	0.988	1.034	0.916
00860	02	Middle NJ	1.032	1.137	0.762
00860	01	Northern NJ	1.059	1.215	0.762
00860	03	Southern NJ	1.024	1.082	0.762
01360	05	New Mexico	0.975	0.903	0.792
00801	01	Buffalo/Surr. Cntys, NY	1.003	0.936	0.821
00803	01	Manhattan, NY	1.095	1.359	1.546
00801	03	N. Central Cities, NY	1.005	0.967	0.821
00803	02	Nyc Suburbs/Long I., NY	1.068	1.235	1.759
00803	03	Poughkpsie/N Nyc Suburbs NY	1.011	1.081	1.218
14330	04	Queens, NY	1.058	1.240	1.686
00801	04	Rest Of New York	0.989	0.937	0.821
00801	02	Rochester/Surr. Cntys, NY	1.012	0.992	0.821
05535	00	North Carolina	0.971	0.918	0.435
00820	01	North Dakota	0.951	0.860	0.617
16360	00	Ohio	0.991	0.940	1.049
01370	00	Oklahoma	0.970	0.882	0.481
01380	02	Eugene, Et Al. (Cities), OR	0.959	0.938	0.637
01380	01	Portland, Et Al. (Cities), OR	0.997	1.000	0.637
01380	99	Rest Of Oregon	0.962	0.907	0.637
01380	03	Salem, Et Al. (Cities), OR	0.965	0.929	0.637
01380	12	Sw OR Cities (City Limits)	0.967	0.954	0.637
00865	02	Lg PA Cities	1.006	1.002	0.936

ADDENDUM B—1996 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality name	Work	Practice expense	Malpractice
00865	01	Philly/Pitt Med Shcls/Hosps. PA	1.027	1.040	1.213
00865	04	Rest Of PA	0.973	0.899	0.719
00865	03	Sm PA Cities	0.983	0.917	0.736
00973	20	Puerto Rico	0.883	0.739	0.268
00870	01	Rhode Island	1.019	1.074	1.569
00880	01	South Carolina	0.976	0.899	0.361
00820	02	South Dakota	0.936	0.856	0.443
05440	35	Tennessee	0.976	0.899	0.524
00900	29	Abilene, TX	0.960	0.851	0.827
00900	26	Amarillo, TX	0.975	0.883	0.827
00900	31	Austin, TX	0.987	0.986	0.827
00900	20	Beaumont, TX	0.993	0.893	1.428
00900	09	Brazoria, TX	0.993	0.966	1.428
00900	10	Brownsville, TX	0.955	0.848	0.827
00900	24	Corpus Christi, TX	0.983	0.898	0.827
00900	11	Dallas, TX	1.012	1.012	0.893
00900	12	Denton, TX	0.968	0.952	0.827
00900	14	El Paso, TX	0.973	0.893	0.893
00900	28	Fort Worth, TX	0.989	0.972	0.893
00900	15	Galveston, TX	0.989	0.966	1.428
00900	16	Grayson, TX	0.959	0.874	0.827
00900	18	Houston, TX	1.021	1.005	1.428
00900	33	Laredo, TX	0.957	0.851	0.827
00900	17	Longview, TX	0.973	0.863	0.827
00900	21	Lubbock, TX	0.955	0.894	0.827
00900	19	Mc Allen, TX	0.961	0.837	0.827
00900	23	Midland, TX	0.991	0.900	0.827
00900	02	Northeast Rural TX	0.960	0.857	0.827
00900	13	Odessa, TX	0.991	0.900	0.827
00900	25	Orange, TX	0.993	0.893	0.827
00900	30	San Angelo, TX	0.948	0.844	0.827
00900	07	San Antonio, TX	0.978	0.926	0.827
00900	03	Southeast Rural TX	0.963	0.872	0.889
00900	06	Temple, TX	0.968	0.884	0.827
00900	08	Texarkana, TX	0.955	0.872	0.827
00900	27	Tyler, TX	0.971	0.894	0.827
00900	32	Victoria, TX	0.983	0.868	0.827
00900	22	Waco, TX	0.966	0.877	0.827
00900	04	Western TX	0.956	0.818	0.827
00900	34	Wichita Falls, TX	0.950	0.857	0.827
00910	09	Utah	0.978	0.891	0.644
00780	50	Vermont	0.974	0.988	0.452
00973	50	Virgin Islands	0.966	0.978	1.023
10490	04	Rest Of VA	0.976	0.876	0.504
10490	01	Richmond & Charlottesville, VA	1.004	0.991	0.511
10490	03	Sm Town/Industrial VA	0.974	0.897	0.517
10490	02	Tidewater & N VA Cntys	0.990	0.965	0.530
01390	03	E Cntrl & Ne WA	0.985	0.943	0.748
01390	02	Seattle (King Cnty), WA	1.006	1.077	0.748
01390	01	W & Se WA (Excl Seattle)	0.982	0.968	0.748
16510	16	Charleston, WV	0.980	0.881	1.004
16510	18	Eastern Valley, WV	0.960	0.899	1.004
16510	19	Ohio River Valley, WV	0.959	0.833	1.004
16510	20	Southern Valley, WV	0.952	0.815	1.004
16510	17	Wheeling, WV	0.957	0.840	1.004
00951	13	Central WI	0.959	0.849	1.160
00951	40	Green Bay (Northeast), WI	0.976	0.894	1.160
00951	54	Janesville (S Cntrl), WI	0.966	0.895	1.160
00951	19	La Crosse (W Cntrl), WI	0.972	0.879	1.160
00951	15	Madison (Dane Cnty), WI	0.990	1.000	1.160
00951	46	Milwaukee Surburbs (Se), WI	0.990	0.959	1.160
00951	04	Milwaukee, WI	1.001	0.978	1.160
00951	12	Northwest WI	0.961	0.850	1.160
00951	60	Oshkosh (E Cntrl), WI	0.973	0.886	1.160
00951	14	Southwest WI	0.959	0.850	1.160
00951	36	Wausau (N Cntrl), WI	0.962	0.866	1.160
00825	21	Wyoming	0.968	0.881	0.811

Note: Work GPCI is the ¼ work GPCI required by Section 1848(e)(1)(A)(iii) of the Social Security Act.
GPCIs rescaled by the following factors to assure budget neutrality: Work=1.00074; Practice expense=1.00125; Malpractice=1.02307.

ADDENDUM C—1995 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier No.	Locality No.	Locality name	Work	Practice expense	Malpractice
00510	05	Birmingham, AL	0.988	0.912	0.876
00510	04	Mobile, AL	0.970	0.884	0.876
00510	02	North Central AL	0.972	0.858	0.876
00510	01	Northwest AL	0.988	0.871	0.876
00510	06	Rest Of AL	0.970	0.834	0.876
00510	03	Southeast AL	0.971	0.864	0.876
01020	01	Alaska	1.085	1.205	1.330
01030	05	Flagstaff, AZ	0.977	0.924	1.288
01030	01	Phoenix, AZ	1.004	0.990	1.288
01030	07	Prescott, AZ	0.977	0.912	1.288
01030	99	Rest Of AZ	0.988	0.946	1.288
01030	02	Tucson, AZ	0.982	0.966	1.288
01030	08	Yuma, AZ	0.984	0.918	1.288
00520	13	Arkansas	0.957	0.854	0.364
02050	26	Anaheim/Santa Ana, CA	1.042	1.212	1.061
00542	14	Bakersfield, CA	1.026	1.021	1.028
00542	11	Fresno/Madera, CA	1.003	0.993	0.983
00542	13	Kings/Tulare, CA	0.993	0.978	0.983
02050	18	Los Angeles (1st Of 8)	1.058	1.202	1.061
02050	19	Los Angeles (2nd Of 8)	1.058	1.202	1.061
02050	20	Los Angeles (3rd Of 8)	1.058	1.202	1.061
02050	21	Los Angeles (4th Of 8)	1.058	1.202	1.061
02050	22	Los Angeles (5th Of 8)	1.058	1.202	1.061
02050	23	Los Angeles (6th Of 8)	1.058	1.202	1.061
02050	24	Los Angeles (7th Of 8)	1.058	1.202	1.061
02050	25	Los Angeles (8th Of 8)	1.058	1.202	1.061
00542	03	Marin/Napa/Solano, CA	1.014	1.189	0.983
00542	10	Merced/Surr.Cntys, CA	1.010	0.998	0.983
00542	12	Monterey/Santa Cruz, CA	1.016	1.126	0.983
00542	01	N. Coastal Cntys, CA	1.003	1.081	0.983
00542	02	Ne Rural, CA	0.992	0.972	0.983
00542	07	Oakland/Berkley, CA	1.035	1.236	0.983
00542	27	Riverside, CA	1.018	1.070	1.018
00542	04	Sacramento/Surr. Cntys,	1.023	1.078	0.983
00542	15	San Bernadino/E.Ctrl Cntys	1.020	1.066	1.060
02050	28	San Diego/Imperial, CA	1.022	1.084	0.994
00542	05	San Francisco, CA	1.053	1.316	0.983
00542	06	San Mateo, CA	1.044	1.302	0.983
02050	16	Santa Barbara, CA	1.014	1.096	1.028
00542	09	Santa Clara, CA	1.056	1.288	0.983
00542	08	Stockton/Surr. Cntys, CA	1.010	1.034	0.983
02050	17	Ventura, CA	1.031	1.162	1.028
00550	01	Colorado	0.994	0.970	0.755
10230	04	Eastern CT	1.016	1.092	1.018
10230	01	Nw And N. Cntrl CT	1.026	1.115	1.013
10230	03	S. Cntrl CT	1.037	1.164	1.094
10230	02	Sw CT	1.054	1.207	1.116
00570	01	Delaware	1.024	1.025	0.728
00580	01	DC + MD/VA Suburbs	1.055	1.180	0.964
00590	03	Fort Lauderdale, FL	0.996	1.008	1.622
00590	04	Miami, FL	1.025	1.056	2.049
00590	02	N/Nc FL Cities	0.976	0.942	1.262
00590	01	Rest Of Florida	0.968	0.892	1.262
01040	01	Atlanta, GA	0.991	1.026	0.827
01040	04	Rest Of GA	0.960	0.848	0.827
01040	02	Small GA Cities 02	0.972	0.906	0.827
01040	03	Small GA Cities 03	0.964	0.876	0.827
01120	01	Hawaii/Guam	1.001	1.157	0.973
05130	12	North Idaho	0.961	0.890	0.738
05130	11	South Idaho	0.965	0.912	0.738
00621	10	Champaign-Urbana, IL	0.958	0.902	1.072
00621	16	Chicago, IL	1.036	1.097	1.578
00621	03	De Kalb, IL	0.966	0.899	0.958
00621	11	Decatur, IL	0.972	0.896	1.008
00621	12	East St. Louis, IL	0.988	0.944	1.390
00621	06	Kankakee, IL	0.966	0.903	1.019
00621	08	Normal, IL	0.983	0.930	0.934
00621	01	Northwest, IL	0.962	0.869	0.934
00621	05	Peoria, IL	0.994	0.968	0.934
00621	07	Quincy, IL	0.960	0.860	0.934
00621	04	Rock Island, IL	0.984	0.908	0.934

ADDENDUM C—1995 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality name	Work	Practice expense	Malpractice
00621	02	Rockford, IL	0.994	0.980	0.975
00621	13	Southeast IL	0.960	0.855	0.934
00621	14	Southern IL	0.960	0.859	0.980
00621	09	Springfield, IL	0.988	0.951	1.042
00621	15	Suburban Chicago, IL	1.014	1.095	1.148
00630	01	Metropolitan IN	0.994	0.950	0.455
00630	03	Rest Of IN	0.976	0.884	0.431
00630	02	Urban IN	0.977	0.900	0.431
00640	05	Des Moines (Polk/Warren) IA	0.988	0.954	0.672
00640	03	North Central Iowa	0.964	0.880	0.672
00640	02	Northeast Iowa	0.968	0.896	0.672
00640	06	Northwest Iowa	0.958	0.868	0.672
00640	04	S Cntrl IA (Excl. Des Moines	0.952	0.859	0.672
00640	01	Southeast Iowa	0.970	0.912	0.672
00640	07	Southwest Iowa	0.960	0.880	0.672
00740	05	Kansas City, Kansas	0.984	0.956	1.162
00650	01	Rest Of Kansas	0.956	0.885	1.162
00740	04	Suburban Kansas City, Kansas	0.984	0.956	1.162
00660	01	Lexington & Louisville, KY	0.986	0.910	0.743
00660	03	Rest Of Kentucky	0.966	0.848	0.743
00660	02	Sm Cities (City Limits), KY	0.968	0.874	0.743
00528	07	Alexandria, LA	0.972	0.876	0.860
00528	03	Baton Rouge, LA	0.988	0.930	0.860
00528	06	Lafayette, LA	0.976	0.892	0.860
00528	04	Lake Charles, LA	0.974	0.904	0.860
00528	05	Monroe, LA	0.968	0.874	0.860
00528	01	New Orleans, LA	0.996	0.974	1.091
00528	50	Rest Of LA	0.968	0.865	0.868
00528	02	Shreveport, LA	0.987	0.914	0.860
21200	02	Central Maine	0.952	0.916	0.738
21200	01	Northern Maine	0.956	0.916	0.738
21200	03	Southern Maine	0.968	1.007	0.738
00690	01	Baltimore/Surr. Cntys, MD	1.024	1.038	1.021
00690	03	South & E. Shore MD	0.998	0.991	0.841
00690	02	Western MD	0.994	0.972	0.852
00700	02	MA Suburbs/Rural Cities	1.006	1.086	0.916
00700	01	Urban MA	1.016	1.149	0.916
00710	01	Detroit, MI	1.051	1.064	2.394
00710	02	Michigan, Not Detroit	1.004	0.953	1.520
00720	00	Minnesota (Blue Shield)	0.994	0.968	0.671
10240	00	Minnesota (Travelers)	0.994	0.968	0.671
10250	01	Rest Of Mississippi	0.955	0.826	0.688
10250	02	Urban Mississippi	0.965	0.885	0.688
00740	03	K.C. (Jackson Cnty), MO	0.984	0.956	1.193
00740	02	N K.C. (Clay/Platte), MO	0.984	0.956	1.192
11260	03	Rest Of MO	0.947	0.828	1.169
00740	06	Rural Nw Counties, MO	0.952	0.850	1.169
11260	02	Sm E. Cities, MO	0.947	0.824	1.169
00740	01	St Joseph, MO	0.951	0.858	1.169
11260	01	St. Louis/Lg E. Cities, MO	0.986	0.942	1.272
00751	01	Montana	0.960	0.895	0.737
00655	00	Nebraska	0.956	0.878	0.440
01290	03	Elko & Ely (Cities), NV	0.984	1.006	1.016
01290	01	Las Vegas, Et Al. (Cities), NV	1.024	1.052	1.016
01290	02	Reno, Et Al. (Cities), NV	1.002	1.095	1.016
01290	99	Rest Of Nevada	1.008	1.046	1.016
00760	40	New Hampshire	0.975	1.022	0.759
00860	02	Middle NJ	1.033	1.104	0.958
00860	01	Northern NJ	1.050	1.173	0.958
00860	03	Southern NJ	1.020	1.056	0.958
01360	05	New Mexico	0.978	0.914	0.780
00801	01	Buffalo/Surr. Cntys, NY	1.004	0.939	0.892
00803	01	Manhattan, NY	1.077	1.307	1.596
00801	03	N. Central Cities, NY	1.001	0.960	0.892
00803	02	Nyc Suburbs/Long I., NY	1.064	1.232	1.844
00803	03	Poughkpsie/N Nyc Suburbs	1.008	1.050	1.272
14330	04	Queens, NY	1.058	1.248	1.774
00801	04	Rest Of New York	0.988	0.936	0.892
00801	02	Rochester/Surr. Cntys, N	1.016	1.004	0.892
05535	00	North Carolina	0.970	0.910	0.406
00820	01	North Dakota	0.958	0.878	0.652

ADDENDUM C—1995 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality name	Work	Practice expense	Malpractice
16360	00	Ohio	0.992	0.946	0.984
01370	00	Oklahoma	0.970	0.896	0.498
01380	02	Eugene, Et Al. (Cities), OR	0.964	0.973	0.794
01380	01	Portland, Et Al. (Cities), OR	0.995	1.016	0.794
01380	99	Rest Of Oregon	0.970	0.952	0.794
01380	03	Salem, Et Al. (Cities),	0.970	0.960	0.794
01380	12	Sw OR Cities (City Limits)	0.970	0.971	0.794
00865	02	Lg PA Cities	1.007	1.002	1.188
00865	01	Philly/Pitt Med Shcls/Hosps, PA	1.020	1.027	1.382
00865	04	Rest Of PA	0.974	0.914	0.852
00865	03	Sm PA Cities	0.984	0.931	0.861
00973	20	Puerto Rico	0.882	0.751	0.367
00870	01	Rhode Island	1.014	1.036	1.152
00880	01	South Carolina	0.974	0.886	0.404
00820	02	South Dakota	0.944	0.856	0.566
05440	35	Tennessee	0.972	0.898	0.466
00900	29	Abilene, TX	0.966	0.870	0.666
00900	26	Amarillo, TX	0.974	0.892	0.666
00900	31	Austin, TX	0.978	0.977	0.666
00900	20	Beaumont, TX	0.996	0.924	0.966
00900	09	Brazoria, TX	1.009	0.960	0.966
00900	10	Brownsville, TX	0.968	0.868	0.666
00900	24	Corpus Christi, TX	0.980	0.921	0.666
00900	11	Dallas, TX	1.004	0.992	0.698
00900	12	Denton, TX	0.982	0.962	0.666
00900	14	El Paso, TX	0.984	0.894	0.698
00900	28	Fort Worth, TX	0.981	0.954	0.698
00900	15	Galveston, TX	0.986	0.967	0.966
00900	16	Grayson, TX	0.962	0.888	0.666
00900	18	Houston, TX	1.018	0.994	1.042
00900	33	Laredo, TX	0.962	0.854	0.666
00900	17	Longview, TX	0.970	0.896	0.666
00900	21	Lubbock, TX	0.952	0.888	0.666
00900	19	Mc Allen, TX	0.953	0.855	0.666
00900	23	Midland, TX	1.007	0.949	0.666
00900	02	Northeast Rural TX	0.964	0.870	0.666
00900	13	Odessa, TX	1.000	0.936	0.666
00900	25	Orange, TX	0.996	0.924	0.666
00900	30	San Angelo, TX	0.951	0.873	0.666
00900	07	San Antonio, TX	0.976	0.928	0.666
00900	03	Southeast Rural TX	0.968	0.884	0.696
00900	06	Temple, TX	0.968	0.885	0.666
00900	08	Texarkana, TX	0.954	0.878	0.666
00900	27	Tyler, TX	0.978	0.912	0.666
00900	32	Victoria, TX	0.980	0.920	0.666
00900	22	Waco, TX	0.974	0.874	0.666
00900	04	Western TX	0.958	0.835	0.666
00900	34	Wichita Falls, TX	0.960	0.876	0.666
00910	09	Utah	0.986	0.922	0.692
00780	50	Vermont	0.958	0.964	0.492
00973	50	Virgin Islands	0.983	0.989	1.012
10490	04	Rest Of VA	0.972	0.882	0.513
10490	01	Richmond & Charlottesville, VA	0.990	0.972	0.486
10490	03	Sm Town/Industrial VA	0.972	0.894	0.524
10490	02	Tidewater & N VA Cntys	0.990	0.980	0.616
01390	03	E Cntrl & Ne WA	0.990	0.969	0.906
01390	02	Seattle (King Cnty), WA	1.012	1.063	0.906
01390	01	W & Se WA (Excl Seattle)	0.995	0.980	0.906
16510	16	Charleston, WV	0.984	0.922	0.846
16510	18	Eastern Valley, WV	0.961	0.890	0.846
16510	19	Ohio River Valley, WV	0.960	0.857	0.846
16510	20	Southern Valley, WV	0.956	0.846	0.846
16510	17	Wheeling, WV	0.966	0.870	0.846
00951	13	Central WI	0.960	0.868	0.961
00951	40	Green Bay (Northeast), WI	0.978	0.904	0.961
00951	54	Janesville (S Cntrl), WI	0.968	0.900	0.961
00951	19	La Crosse (W Cntrl), WI	0.974	0.899	0.961
00951	15	Madison (Dane Cnty), WI	0.984	0.990	0.961
00951	46	Milwaukee Surburbs (Se), WI	1.000	0.984	0.961
00951	04	Milwaukee, WI	1.004	0.994	0.961
00951	12	Northwest WI	0.964	0.874	0.961

ADDENDUM C—1995 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality name	Work	Practice expense	Malpractice
00951	60	Oshkosh (E Cntrl), WI	0.974	0.898	0.961
00951	14	Southwest WI	0.960	0.869	0.961
00951	36	Wausau (N Cntrl), WI	0.966	0.882	0.961
00825	21	Wyoming	0.978	0.910	0.726

Note: Work GPCI is the ¼ work GPCI required by Section 1848(e)(1)(A)(iii) of the Social Security Act.
GPCIs rescaled by the following factors to assure budget neutrality: Work=1.00073; Practice expense=1.00125; Malpractice=1.02307.

ADDENDUM D.—CHANGES IN GEOGRAPHIC ADJUSTMENT FACTOR 1996 VS. 1994 (in Descending Order)

Carrier No.	Locality No.	Locality name	1996 GAF	1994 GAF	Change	Percent change
00870	01	Rhode Island	1.068	0.991	0.077	7.8
10230	03	S. Cntrl CT	1.123	1.061	0.062	5.8
10230	01	Nw And N. Cntrl CT	1.092	1.031	0.061	5.9
00803	01	Manhattan, NY	1.225	1.168	0.057	4.9
00590	04	Miami, FL	1.114	1.059	0.055	5.2
00900	18	Houston, TX	1.034	0.984	0.050	5.1
10230	04	Eastern CT	1.072	1.023	0.049	4.8
00590	03	Fort Lauderdale, FL	1.055	1.006	0.049	4.9
00900	15	Galveston, TX	1.001	0.953	0.048	5.0
10230	02	Sw CT	1.143	1.097	0.046	4.2
01120	01	Hawaii/Guam	1.086	1.041	0.045	4.3
00900	11	Dallas, TX	1.006	0.962	0.044	4.6
00900	28	Fort Worth, TX	0.977	0.935	0.042	4.5
00780	40	New Hampshire	1.003	0.965	0.038	3.9
21200	03	Southern Maine	0.992	0.954	0.038	4.0
00700	01	Urban MA	1.084	1.048	0.036	3.4
00590	01	Rest of Florida	0.969	0.934	0.035	3.7
00951	15	Madison (Dane Cnty), WI	1.002	0.968	0.034	3.5
10490	01	Richmond & Charlottesville, VA	0.975	0.941	0.034	3.6
00780	50	Vermont	0.955	0.922	0.033	3.6
00900	31	Austin, TX	0.979	0.946	0.033	3.5
00900	09	Brazoria, TX	1.003	0.971	0.032	3.3
00710	01	Detroit, MI	1.137	1.105	0.032	2.9
01040	01	Atlanta, GA	1.011	0.984	0.027	2.7
01040	02	Small GA Cities 02	0.951	0.924	0.027	2.9
00700	02	MA Suburbs/Rural Cities	1.048	1.021	0.027	2.6
00860	01	Northern NJ	1.109	1.083	0.026	2.4
00803	03	Poughkpsie/N NYC Suburb, NY	1.050	1.025	0.025	2.4
00590	02	N/Nc FL Cities	0.988	0.964	0.024	2.5
00900	21	Lubbock, TX	0.924	0.900	0.024	2.7
21200	02	Central Maine	0.938	0.915	0.023	2.5
16510	18	Eastern Valley, WV	0.937	0.916	0.021	2.3
01040	04	Rest Of GA	0.917	0.899	0.018	2.0
00900	07	San Antonio, TX	0.949	0.932	0.017	1.8
01040	03	Small GA Cities 03	0.929	0.913	0.016	1.8
00900	20	Beaumont, TX	0.973	0.957	0.016	1.7
21200	01	Northern Maine	0.936	0.922	0.014	1.5
00900	06	Temple, TX	0.927	0.913	0.014	1.5
00951	54	Janesville (S Cntrl), WI	0.946	0.933	0.013	1.4
00900	08	Texarkana, TX	0.915	0.903	0.012	1.3
00510	05	Birmingham, AL	0.957	0.946	0.011	1.2
05535	00	North Carolina	0.924	0.913	0.011	1.2
05440	35	Tennessee	0.923	0.912	0.011	1.2
00570	01	Delaware	1.015	1.005	0.010	1.0
00710	02	Michigan, Not Detroit	1.013	1.003	0.010	1.0
00900	26	Amarillo, TX	0.930	0.920	0.010	1.1
00900	19	Mc Allen, TX	0.904	0.894	0.010	1.1
00900	22	Waco, TX	0.923	0.913	0.010	1.1
00510	01	Northwest AL	0.939	0.930	0.009	1.0
01030	08	Yuma, AZ	0.976	0.967	0.009	0.9
00880	01	South Carolina	0.915	0.906	0.009	0.0
00951	40	Green Bay (Northeast), W	0.951	0.942	0.009	1.0
00860	02	Middle NJ	1.062	1.054	0.008	0.8
00951	60	Oshkosh (E Cntrl), WI	0.946	0.938	0.008	0.9
00900	33	Laredo, TX	0.907	0.900	0.007	0.8
00580	01	DC + MD/VA Suburbs	1.105	1.098	0.007	0.6
00860	03	Southern NJ	1.035	1.028	0.007	0.7
01030	05	Flagstaff, AZ	0.973	0.967	0.006	0.6

ADDENDUM D.—CHANGES IN GEOGRAPHIC ADJUSTMENT FACTOR 1996 VS. 1994 (in Descending Order)—Continued

Carrier No.	Locality No.	Locality name	1996 GAF	1994 GAF	Change	Percent change
01030	99	Rest Of AZ	0.988	0.982	0.006	0.6
00900	14	El Paso, TX	0.936	0.930	0.006	0.6
00660	01	Lexington & Louisville, KY	0.946	0.941	0.005	0.5
00690	01	Baltimore/Surr. Cntys, MD	1.032	1.028	0.004	0.4
00801	03	N. Central Cities, NY	0.981	0.977	0.004	0.4
00900	03	Southeast Rural TX	0.922	0.919	0.003	0.3
10490	03	Sm Town/Industrial VA	0.920	0.917	0.003	0.3
00951	13	Central WI	0.924	0.921	0.003	0.3
00951	14	Southwest WI	0.924	0.921	0.003	0.3
00740	05	Kansas City, Kansas	0.982	0.980	0.002	0.2
00740	04	Suburban Kansas City, Kansas	0.982	0.980	0.002	0.2
00528	04	Lake Charles, LA	0.941	0.939	0.002	0.2
00951	04	Milwaukee, WI	0.999	0.997	0.002	0.2
00520	13	Arkansas	0.887	0.886	0.001	0.1
00740	03	K.C. (Jackson Cnty), MO	0.983	0.982	0.001	0.1
00740	02	N K.C. (Clay/Platte), MO	0.983	0.982	0.001	0.1
16360	00	Ohio	0.973	0.972	0.001	0.1
00900	24	Corpus Christi, TX	0.941	0.940	0.001	0.1
00900	16	Grayson, TX	0.918	0.917	0.001	0.1
00951	19	La Crosse (W Cntrl), WI	0.943	0.942	0.001	0.1
00951	36	Wausau (N Cntrl), WI	0.932	0.931	0.001	0.1
00865	01	Philly/Pitt Med Shcls/Hosps, PA	1.041	1.040	0.001	0.1
00900	02	Northeast Rural TX	0.911	0.911	0.000	0.0
00510	02	North Central AL	0.920	0.921	−0.001	−0.1
00510	03	Southeast AL	0.922	0.923	−0.001	−0.1
00650	01	Rest Of Kansas	0.936	0.937	−0.001	−0.1
00900	04	Western TX	0.893	0.894	−0.001	−0.1
10490	04	Rest Of VA	0.912	0.913	−0.001	−0.1
00803	02	Nyc Suburbs/Long I., NY	1.170	1.171	−0.001	−0.1
01030	07	Prescott, AZ	0.964	0.967	−0.003	−0.3
00951	12	Northwest WI	0.925	0.928	−0.003	−0.3
00801	04	Rest Of New York	0.960	0.965	−0.005	−0.5
00900	29	Abilene, TX	0.909	0.915	−0.006	−0.7
00900	27	Tyler, TX	0.933	0.939	−0.006	−0.6
16510	19	Ohio River Valley, WV	0.910	0.916	−0.006	−0.7
00621	15	Suburban Chicago, IL	1.050	1.057	−0.007	−0.7
00900	12	Denton, TX	0.955	0.962	−0.007	−0.7
00740	01	St Joseph, MO	0.920	0.927	−0.007	−0.8
00655	00	Nebraska	0.894	0.903	−0.009	−1.0
00900	17	Longview, TX	0.921	0.930	−0.009	−1.0
01390	02	Seattle (King Cnty), WA	1.023	1.033	−0.010	−1.0
00542	05	San Francisco, CA	1.153	1.163	−0.010	−0.9
00510	04	Mobile, AL	0.925	0.936	−0.011	−1.2
01360	05	New Mexico	0.937	0.948	−0.011	−1.2
00801	01	Buffalo/Surr. Cntys, NY	0.967	0.978	−0.011	−1.1
00900	30	San Angelo, TX	0.900	0.911	−0.011	−1.2
00900	34	Wichita Falls, TX	0.906	0.917	−0.011	−1.2
02050	17	Ventura, CA	1.079	1.090	−0.011	−1.0
02050	16	Santa Barbara, CA	1.042	1.054	−0.012	−1.1
00528	05	Monroe, LA	0.918	0.930	−0.012	−1.3
00528	50	Rest Of LA	0.915	0.927	−0.012	−1.3
10250	01	Rest Of Mississippi	0.883	0.895	−0.012	−1.3
10250	02	Urban Mississippi	0.913	0.925	−0.012	−1.3
00951	46	Milwaukee Surburbs (Se), WI	0.985	0.997	−0.012	−1.2
00550	01	Colorado	0.966	0.979	−0.013	−1.3
01370	00	Oklahoma	0.910	0.923	−0.013	−1.4
00900	25	Orange, TX	0.944	0.957	−0.013	−1.4
00720	00	Minnesota (Blue Shield)	0.961	0.975	−0.014	−1.4
10240	00	Minnesota (Travelers)	0.961	0.975	−0.014	−1.4
00900	10	Brownsville, TX	0.905	0.919	−0.014	−1.5
14330	04	Queens, NY	1.163	1.178	−0.015	−1.3
00510	06	Rest Of AL	0.902	0.917	−0.015	−1.6
00630	02	Urban IN	0.912	0.927	−0.015	−1.6
00740	06	Rural Nw Counties, MO	0.913	0.928	−0.015	−1.6
16510	20	Southern Valley, WV	0.898	0.913	−0.015	−1.6
00640	05	Des Moines (Polk/Warren), IA	0.950	0.968	−0.018	−1.9
01030	01	Phoenix, AZ	1.002	1.020	−0.018	−1.8
10490	02	Tidewater & N VA Cntys	0.958	0.977	−0.019	−1.9
00973	20	Puerto Rico	0.794	0.813	−0.019	−2.3
16510	17	Wheeling, WV	0.911	0.930	−0.019	−2.0
00528	07	Alexandria, LA	0.917	0.937	−0.020	−2.1

ADDENDUM D.—CHANGES IN GEOGRAPHIC ADJUSTMENT FACTOR 1996 VS. 1994 (in Descending Order)—Continued

Carrier No.	Locality No.	Locality name	1996 GAF	1994 GAF	Change	Percent change
11260	03	Rest Of MO	0.899	0.919	−0.020	−2.2
11260	02	Sm E. Cities, MO	0.897	0.917	−0.020	−2.2
00820	02	South Dakota	0.880	0.900	−0.020	−2.2
16510	16	Charleston, WV	0.941	0.962	−0.021	−2.2
00660	02	Sm Cities (City Limits), KY	0.908	0.929	−0.021	−2.3
01030	02	Tucson, AZ	0.980	1.001	−0.021	−2.1
00630	03	Rest Of IN	0.901	0.923	−0.022	−2.4
00640	02	Northeast Iowa	0.913	0.935	−0.022	−2.4
00801	02	Rochester/Surr. Cntys, N	0.995	1.017	−0.022	−2.2
00900	13	Odessa, TX	0.946	0.969	−0.023	−2.4
00640	01	Southeast Iowa	0.920	0.943	−0.023	−2.4
00630	01	Metropolitan IN	0.938	0.962	−0.024	−2.5
00865	03	Sm PA Cities	0.944	0.968	−0.024	−2.5
00640	07	Southwest Iowa	0.902	0.926	−0.024	−2.6
00660	03	Rest Of Kentucky	0.895	0.919	−0.024	−2.6
00900	32	Victoria, TX	0.928	0.952	−0.024	−2.5
00865	02	Lg PA Cities	1.001	1.026	−0.025	−2.4
00820	01	North Dakota	0.898	0.923	−0.025	−2.7
00973	50	Virgin Islands	0.974	1.000	−0.026	−2.6
00825	21	Wyoming	0.925	0.951	−0.026	−2.7
01380	01	Portland, Et Al. (Cities), OR	0.981	1.007	−0.026	−2.6
00542	09	Santa Clara, CA	1.134	1.161	−0.027	−2.3
00865	04	Rest Of PA	0.930	0.957	−0.027	−2.8
00690	03	South & E. Shore MD	0.974	1.001	−0.027	−2.7
00528	03	Baton Rouge, LA	0.944	0.972	−0.028	−2.9
02050	18	Los Angeles (1st Of 8)	1.103	1.131	−0.028	−2.5
02050	19	Los Angeles (2nd Of 8)	1.103	1.131	−0.028	−2.5
02050	20	Los Angeles (3rd Of 8)	1.103	1.131	−0.028	−2.5
02050	21	Los Angeles (4th Of 8)	1.103	1.131	−0.028	−2.5
02050	22	Los Angeles (5th Of 8)	1.103	1.131	−0.028	−2.5
02050	23	Los Angeles (6th Of 8)	1.103	1.131	−0.028	−2.5
02050	24	Los Angeles (7th Of 8)	1.103	1.131	−0.028	−2.5
02050	25	Los Angeles (8th Of 8)	1.103	1.131	−0.028	−2.5
00621	10	Champaign-Urbana, IL	0.927	0.955	−0.028	−2.9
11260	01	St. Louis/Lg E. Cities, MO	0.968	0.996	−0.028	−2.8
00621	09	Springfield, IL	0.961	0.990	−0.029	−2.9
00640	06	Northwest Iowa	0.893	0.922	−0.029	−3.1
00640	04	S Cntrl IA (Excl. Des Moines)	0.886	0.915	−0.029	−3.2
01290	03	Elko & Ely (Cities), NV	0.980	1.009	−0.029	−2.9
00542	01	N. Coastal Cntys, CA	1.019	1.049	−0.030	−2.9
00528	01	New Orleans, LA	0.977	1.007	−0.030	−3.0
00542	12	Monterey/Santa Cruz, CA	1.044	1.075	−0.031	−2.9
00528	06	Lafayette, LA	0.921	0.952	−0.031	−3.3
00751	01	Montana	0.907	0.938	−0.031	−3.3
00621	12	East St. Louis, IL	0.974	1.005	−0.031	−3.1
00542	06	San Mateo, CA	1.130	1.163	−0.033	−2.8
00528	02	Shreveport, LA	0.935	0.968	−0.033	−3.4
01380	12	Sw OR Cities (City Limits)	0.946	0.979	−0.033	−3.4
01020	01	Alaska	1.128	1.164	−0.036	−3.1
00621	06	Kankakee, IL	0.924	0.961	−0.037	−3.9
05130	11	South Idaho	0.914	0.951	−0.037	−3.9
00640	03	North Central Iowa	0.897	0.934	−0.037	−4.0
00910	09	Utah	0.926	0.964	−0.038	−3.9
01390	01	W & Se WA (Excl Seattle)	0.965	1.004	−0.039	−3.9
02050	26	Anaheim/Santa Ana, CA	1.092	1.133	−0.041	−3.6
00542	08	Stockton/Surr. Cntys, CA	0.998	1.039	−0.041	−3.9
05130	12	North Idaho	0.901	0.942	−0.041	−4.4
00900	23	Midland, TX	0.946	0.988	−0.042	−4.3
00542	03	Marin/Napa/Solano, CA	1.063	1.105	−0.042	−3.8
00621	16	Chicago, IL	1.066	1.108	−0.042	−3.8
01390	03	E Cntrl & Ne WA	0.956	0.999	−0.043	−4.3
00542	15	San Bernadino/E.Ctrl Cntys, CA	1.019	1.063	−0.044	−4.1
01380	03	Salem, Et Al. (Cities), OR	0.934	0.979	−0.045	−4.6
00690	02	Western MD	0.955	1.001	−0.046	−4.6
00542	07	Oakland/Berkley, CA	1.092	1.139	−0.047	−4.1
02050	28	San Diego/Imperial, CA	1.022	1.069	−0.047	−4.4
00621	11	Decatur, IL	0.918	0.966	−0.048	−5.0
00542	04	Sacramento/Surr. Cntys, CA	1.020	1.068	−0.048	−4.5
01380	02	Eugene, Et Al. (Cities), OR	0.935	0.984	−0.049	−5.0
01290	01	Las Vegas, Et Al. (Cities), NV	1.010	1.060	−0.050	−4.7
00542	27	Riverside, CA	1.014	1.065	−0.051	−4.8

ADDENDUM D.—CHANGES IN GEOGRAPHIC ADJUSTMENT FACTOR 1996 VS. 1994 (in Descending Order)—Continued

Carrier No.	Locality No.	Locality name	1996 GAF	1994 GAF	Change	Percent change
00621	03	De Kalb, IL	0.912	0.964	−0.052	−5.4
01290	99	Rest Of Nevada	0.998	1.050	−0.052	−5.0
00542	11	Fresno/Madera, CA	0.971	1.025	−0.054	−5.3
00542	10	Merced/Surr.Cntys, CA	0.977	1.031	−0.054	−5.2
00621	01	Northwest, IL	0.896	0.950	−0.054	−5.7
01290	02	Reno, Et Al. (Cities), NV	1.013	1.069	−0.056	−5.2
00542	14	Bakersfield, CA	0.994	1.053	−0.059	−5.6
01380	99	Rest Of Oregon	0.924	0.985	−0.061	−6.2
00621	14	Southern IL	0.889	0.950	−0.061	−6.4
00542	02	Ne Rural, CA	0.952	1.014	−0.062	−6.1
00542	13	Kings/Tulare, CA	0.955	1.018	−0.063	−6.2
00621	07	Quincy, IL	0.886	0.950	−0.064	−6.7
00621	02	Rockford, IL	0.955	1.019	−0.064	−6.3
00621	08	Normal, IL	0.926	0.992	−0.066	−6.7
00621	13	Southeast IL	0.882	0.950	−0.068	−7.2
00621	04	Rock Island, IL	0.914	0.987	−0.073	−7.4
00621	05	Peoria, IL	0.938	1.024	−0.086	−8.4

Note: Work GPCI is the ¼ work GPCI required by Section 1848 (e)(1)(A)(iii) of the Social Security Act.
GPCIs rescaled by the following factors to assure budget neutrality: Work=1.00073; Practice expense=1.00125; Malpractice=1.02307.

ADDENDUM E.—1996 GEOGRAPHIC PRACTICE COST INDICES AND GEOGRAPHIC ADJUSTMENT FACTORS FOR STATES WITH MULTIPLE LOCALITIES

State name	Work	Practice expense	Malpractice	1996 GAF
Alabama	0.980	0.870	0.927	0.932
Arizona	0.996	0.956	1.321	0.995
California	1.033	1.145	0.668	1.061
Connecticut	1.050	1.192	1.001	1.106
Florida	0.988	0.991	1.697	1.023
Georgia	0.986	0.948	0.902	0.966
Idaho	0.961	0.882	0.538	0.911
Illinois	1.002	1.007	1.157	1.011
Indiana	0.982	0.916	0.356	0.925
Iowa	0.960	0.877	0.679	0.912
Kansas	0.964	0.892	1.191	0.945
Kentucky	0.971	0.868	0.819	0.921
Louisiana	0.979	0.896	0.940	0.943
Maine	0.969	0.969	0.759	0.959
Maryland*	1.012	1.016	1.056	1.016
Massachusetts	1.026	1.150	0.978	1.075
Michigan	1.023	0.992	2.509	1.082
Mississippi	0.958	0.844	0.726	0.900
Missouri	0.974	0.900	1.188	0.954
Nevada	1.007	1.029	0.887	1.010
New Jersey	1.047	1.173	0.762	1.085
New York	1.050	1.167	1.410	1.115
Oregon	0.974	0.952	0.637	0.949
Pennsylvania	1.002	0.982	0.933	0.990
Texas	0.985	0.930	0.974	0.962
Virginia*	0.986	0.938	0.518	0.944
Washington	0.990	0.998	0.748	0.982
West Virginia	0.964	0.851	1.004	0.920
Wisconsin	0.982	0.926	1.160	0.968

*The Maryland and Virginia state GPCIs do not include the parts of Maryland, Virginia included in the District of Columbia physician fee schedule area. The District of Columbia fee schedule area includes Washington, D.C.; Prince Georges and Montgomery Counties in Maryland; and Fairfax and Arlington Counties and the City of Alexandria in Virginia.
Note: Work GPCI is the ¼ work GPCI required by Section 1848(e)(1)(A)(iii) of the Social Security Act.
GPCIs rescaled by the following factors to assure budget neutrality: Work=1.00073; Practice expense=1.00125; Malpractice=1.02307.

ADDENDUM F.—1995 GEOGRAPHIC PRACTICE COST INDICES AND GEOGRAPHIC ADJUSTMENT FACTORS FOR STATES WITH MULTIPLE LOCALITIES

State name	Work	Practice expense	Malpractice	1995 GAF
Alabama	0.978	0.878	0.876	0.932
Arizona	0.996	0.978	1.288	1.003
California*	1.034	1.148	1.019	1.080

ADDENDUM F.—1995 GEOGRAPHIC PRACTICE COST INDICES AND GEOGRAPHIC ADJUSTMENT FACTORS FOR STATES WITH MULTIPLE LOCALITIES—Continued

State name	Work	Practice expense	Malpractice	1995 GAF
Connecticut	1.032	1.140	1.051	1.077
Florida	0.988	0.972	1.480	1.005
Georgia	0.976	0.941	0.827	0.954
Idaho	0.964	0.907	0.738	0.930
Illinois	1.010	1.028	1.311	1.032
Indiana	0.986	0.926	0.445	0.935
Iowa	0.968	0.898	0.672	0.925
Kansas	0.961	0.900	1.162	0.946
Kentucky	0.975	0.885	0.743	0.927
Louisiana	0.983	0.920	0.939	0.955
Maine	0.959	0.953	0.738	0.946
Maryland*	1.017	1.024	0.980	1.018
Massachusetts	1.014	1.133	0.916	1.058
Michigan	1.030	1.015	2.001	1.070
Mississippi	0.960	0.859	0.688	0.906
Missouri	0.976	0.918	1.232	0.965
Nevada	1.017	1.063	1.016	1.036
New Jersey	1.040	1.136	0.958	1.075
New York	1.045	1.156	1.484	1.112
Oregon	0.977	0.980	0.794	0.969
Pennsylvania	1.002	0.984	1.128	1.001
Texas	0.984	0.931	0.752	0.951
Virginia*	0.982	0.938	0.540	0.943
Washington	1.000	1.004	0.906	0.997
West Virginia	0.968	0.882	0.846	0.927
Wisconsin	0.985	0.940	0.961	0.965

*The Maryland and Virginia state GPCIs do not include the parts of Maryland and Virginia included in the District of Columbia physician fee schedule area. The District of Columbia fee schedule area includes Washington, D.C.; Prince George's and Montgomery Counties in Maryland; and Fairfax and Arlington Counties and the City of Alexandria in Virginia.

Note: Work GPCI is the ¼ work GPCI required by Section 1848(e)(1)(A)(iii) of the Social Security Act.
GPCI is rescaled by the following factors to assure budget neutrality: Work=1.00073; Practice expense=1.00125; Malpractice=1.02307.

ADDENDUM G.—REFERENCE SET WITH 1994 WORK RVUS

HCPCS*	Work RVU	Description (short)
11200	0.70	Removal of skin tags.
11401	1.28	Removal of skin lesion.
11446	4.49	Removal of skin lesion.
11750	1.68	Removal of nail bed.
13101	3.91	Repair of wound or lesion.
17002	0.19	Destruction of add'l lesion.
19140	4.95	Removal of breast tissue.
20610	0.80	Drain/inject joint/bursa.
22600	18.25	Neck spine fusion.
25605	5.42	Treat fracture radius/ulna.
26055	2.59	Incise finger tendon sheath.
27130	18.89	Total hip replacement.
27235	11.14	Repair of thigh fracture.
27244	14.51	Repair of thigh fracture.
27447	19.91	Total knee replacement.
27590	10.35	Amputate leg at thigh.
29881	7.54	Knee arthroscopy/surgery.
30115	4.30	Removal of nasal polyp(s).
31500	2.36	Insert emergency airway.
31505	0.62	Diagnostic laryngoscopy.
31575	1.11	Diagnostic laryngoscopy.
31622	2.83	Diagnostic bronchoscopy.
31625	3.41	Bronchoscopy with biopsy.
32000	1.56	Drainage of chest.
32020	4.02	Insertion of chest tube.
32100	10.18	Exploration/biopsy of chest.
33870	38.16	Transverse aortic arch graft.
35081	22.40	Repair defect of artery.
35301	16.13	Rechanneling of artery.
35371	10.61	Rechanneling of artery.
35656	14.01	Artery bypass graft.
36620	1.16	Insertion catheter, artery.
37140	22.40	Revision of circulation.

ADDENDUM G.—REFERENCE SET WITH 1994 WORK RVUs—Continued

HCPCS*	Work RVU	Description (short)
37609	2.30	Temporal artery procedure.
38300	1.50	Drainage lymph node lesion.
41100	1.60	Biopsy of tongue.
43450	1.40	Dilate esophagus.
43832	10.80	Place gastrostomy tube.
44130	11.21	Bowel to bowel fusion.
44950	6.13	Appendectomy.
45110	21.92	removal of rectum.
45305	1.02	Proctosigmoidoscopy; biopsy.
46221	1.40	Ligation of hemorrhoid(s).
46936	4.22	destruction of hemorrhoids.
47100	6.83	Wedge biopsy of liver.
48150	34.55	Partial removal of pancreas.
52000	2.03	Cystoscopy.
54161	3.26	Circumcision.
55700	1.59	Biopsy of prostate.
58120	2.48	Dilation and curettage (d&c).
58150	13.14	Total hysterectomy.
58260	11.52	Vaginal hysterectomy.
58720	6.27	Removal of ovary/tubes(s).
60220	9.97	Partial removal of thyroid.
60500	15.57	Explore parathyroid glands.
62270	1.14	Spinal fluid tap, diagnostic.
63047	12.90	Removal of spinal lamina.
63780	6.29	Insert spinal canal catheter.
64721	4.03	Carpal tunnel surgery.
65285	12.19	Repair of eye wound.
65730	11.96	Corneal transplant.
65855	4.70	Laser surgery of eye.
66821	2.81	After cataract laser surgery.
67036	11.46	Removal of inner eye fluid.
67107	14.15	Repair detached retina.
67801	1.87	Remove eyelid lesions.
69433	1.49	Creat eardrum opening.
69641	12.43	Revise middle ear & mastoid.
70150	0.26	X-ray exam of facial bones.
70450	0.86	cat scan of head or brain.
70470	1.28	Contrast cat scans of head.
70551	1.5	Magnetic image, brain (mri).
71010	0.18	Chest x-ray.
72020	0.15	X-ray exam of spine.
73620	0.16	X-ray exam of foot.
76516	0.55	Echo exam of eye.
76700	0.82	Echo exam of abdomen.
77425	2.47	Weekly radiation therapy.
78306	0.87	Bone imaging, whole body.
78465	1.48	Heart image (3d) multiple.
80500	0.37	Lab pathology consultation.
85060	0.46	Blood smear interpretation.
88300	0.08	Surg path, gross.
88309	2.31	Tissue exam by pathologist.
90844	1.74	Psychotherapy 45–50 min.
91010	1.67	Esophagus motility study.
92225	0.59	Special eye exam, initial.
99201	0.38	Office/outpatient visit, new.
99202	0.76	Office/outpatient visit, new.
99204	1.73	Office/outpatient visit, new.
99205	2.31	Office/outpatient visit, new.
99211	0.17	Office/outpatient visit, est.
99212	0.38	Office/outpatient visit, est.
99213	0.56	Office/outpatient visit, est.
99214	0.95	Office/outpatient visit, est.
99215	1.53	Office/outpatient visit, est.
99221	1.07	Initial hospital care.
99222	1.86	Initial hospital care.
99223	2.6	Initial hospital care.
99231	0.52	Subsequent hospital care.
99232	0.89	Subsequent hospital care.
99233	1.26	Subsequent hospital care.
99251	0.55	Initial inpatient consult.
99252	1.14	Initial inpatient consult.
99253	1.58	Initial inpatient consult.

ADDENDUM G.—REFERENCE SET WITH 1994 WORK RVUS—Continued

HCPCS*	Work RVU	Description (short)
99254	2.3	Initial inpatient consult.
99255	3.17	Initial Inpatient consult.
99281	0.28	Emergency dept visit.
99282	0.48	Emergency dept visit.
99285	2.66	Emergency dept visit.

*All numeric CPT HCPCS copyright 1993 American Medical Association.

ADDENDUM H.—PROCEDURE CODES SUBJECT TO THE SITE-OF-SERVICE DIFFERENTIAL

HCPCS	Description
10040	Acne surgery.
10060	Drainage of skin abscess.
10061	Drainage of skin abscess.
10080	Drainage of pilonidal cyst.
*10081	Drainage of pilonidal cyst.
10120	Remove foreign body.
10121	Remove foreign body.
10140	Drainage of hematoma/fluid.
10160	Puncture drainage of lesion.
11000	Surgical cleansing of skin.
11001	Additional cleansing of skin.
11040	Surgical cleansing, abrasion.
11041	Surgical cleansing of skin.
11050	Trim skin lesion.
11051	Trim 2 to 4 skin lesions.
11052	Trim over 4 skin lesions.
11100	Biopsy of skin lesion.
11101	Biopsy, each added lesion.
11200	Removal of skin tags.
11201	Removal of added skin tags.
11300	Shave skin lesion.
11301	Shave skin lesion.
11302	Shave skin lesion.
*11303	Shave skin lesion.
11305	Shave skin lesion.
11306	Shave skin lesion.
11307	Shave skin lesion.
*11308	Shave skin lesion.
11310	Shave skin lesion.
11311	Shave skin lesion.
11312	Shave skin lesion.
*11313	Shave skin lesion.
11400	Removal of skin lesion.
11401	Removal of skin lesion.
11402	Removal of skin lesion.
11403	Removal of skin lesion.
11420	Removal of skin lesion.
11421	Removal of skin lesion.
11422	Removal of skin lesion.
11423	Removal of skin lesion.
11440	Removal of skin lesion.
11441	Removal of skin lesion.
11442	Removal of skin lesion.
11443	Removal of skin lesion.
11600	Removal of skin lesion.
11601	Removal of skin lesion.
11602	Removal of skin lesion.
11603	Removal of skin lesion.
11620	Removal of skin lesion.
11621	Removal of skin lesion.
11622	Removal of skin lesion.
11623	Removal of skin lesion.
11640	Removal of skin lesion.
11641	Removal of skin lesion.
11642	Removal of skin lesion.
11643	Removal of skin lesion.
11700	Scraping of 1–5 nails.
11701	Scraping of additional nails.

ADDENDUM H.—PROCEDURE CODES SUBJECT TO THE SITE-OF-SERVICE DIFFERENTIAL—Continued

HCPCS	Description
11710	Scraping of 1–5 nails.
11711	Scraping of additional nails.
11730	Removal of nail plate.
11731	Removal of second nail plate.
11732	Removal of additional nail plate.
11740	Drain blood from under nail.
11750	Removal of nail bed.
*11752	Remove nail bed/finger tip.
11760	Reconstruction of nail bed.
11762	Reconstruction of nail bed.
11765	Excision of nail fold, toe.
11900	Injection into skin lesions.
11901	Added skin lesion injections.
*12031	Layer closure of wound(s).
*12032	Layer closure of wound(s).
*12041	Layer closure of wound(s).
*12042	Layer closure of wound(s).
*12051	Layer closure of wound(s).
*12052	Layer closure of wound(s).
*15780	Abrasion treatment of skin.
*15781	Abrasion treatment of skin.
*15782	Abrasion treatment of skin.
*15783	Abrasion treatment of skin.
*15786	Abrasion treatment of lesion.
*15787	Abrasion, added skin lesions.
15851	Removal of sutures.
*15852	Dressing change, not for burn.
16000	Initial treatment of burn(s).
16010	Treatment of burn(s).
16020	Treatment of burn(s).
16025	Treatment of burn(s).
17000	Destroy benign/premal lesion.
17001	Destruction of add'l lesions.
17002	Destruction of add'l lesions.
17010	Destruction skin lesion(s).
17100	Destruction of skin lesion.
17101	Destruction of 2nd lesion.
17102	Destruction of add'l lesions.
17104	Destruction of skin lesions.
17105	Destruction of skin lesions.
*17106	Destruction of skin lesions.
*17107	Destruction of skin lesions.
*17110	Destruction of skin lesions.
17200	Electrocautery of skin tags.
17201	Electrocautery added lesions.
17250	Chemical cautery, tissue.
*17260	Destruction of skin lesions.
*17261	Destruction of skin lesions.
*17262	Destruction of skin lesions.
*17263	Destruction of skin lesions.
*17264	Destruction of skin lesions.
*17266	Destruction of skin lesions.
*17270	Destruction of skin lesions.
*17271	Destruction of skin lesions.
*17272	Destruction of skin lesions.
*17273	Destruction of skin lesions.
*17274	Destruction of skin lesions.
*17276	Destruction of skin lesions.

ADDENDUM H.—PROCEDURE CODES SUBJECT TO THE SITE-OF-SERVICE DIFFERENTIAL—Continued

HCPCS	Description
*17280	Destruction of skin lesions.
*17281	Destruction of skin lesions.
*17282	Destruction of skin lesions.
*17283	Destruction of skin lesions.
*17284	Destruction of skin lesions.
*17286	Destruction of skin lesions.
*17304	Chemosurgery of skin lesion.
17305	2nd stage chemosurgery.
17306	3rd stage chemosurgery.
17307	Followup skin lesion therapy.
17310	Extensive skin chemosurgery.
17340	Cryotherapy of skin.
17360	Skin peel therapy.
19000	Drainage of breast lesion.
*19001	Drain added breast lesion.
20000	Incision of abscess.
20500	Injection of sinus tract.
20520	Removal of foreign body.
20550	Inj tendon/ligament/cyst.
20600	Drain/inject joint/bursa.
20605	Drain/inject joint/bursa.
20610	Drain/inject joint/bursa.
20615	Treatment of bone cyst.
*20974	Electrical bone stimulation.
*21029	Contour of face bone lesion.
21030	Removal of face bone lesion.
*21031	Remove exostosis, mandible.
*21032	Remove exostosis, maxilla.
*21079	Prepare face/oral prosthesis.
*21080	Prepare face/oral prosthesis.
*21081	Prepare face/oral prosthesis.
*21082	Prepare face/oral prosthesis.
*21083	Prepare face/oral prosthesis.
*21084	Prepare face/oral prosthesis.
*21085	Prepare face/oral prosthesis.
*21086	Prepare face/oral prosthesis.
*21087	Prepare face/oral prosthesis.
*21088	Prepare face/oral prosthesis.
*21089	Prepare face/oral prosthesis.
*21110	Interdental fixation.
*21499	Head surgery procedure.
*23031	Drain shoulder bursa.
*24200	Removal of arm foreign body.
24650	Treat radius facture.
25500	Treat fracture of radius.
*25530	Treat fracture of ulna.
*25600	Treat fracture radius/ulna.
*25622	Treat wrist bone fracture.
*25630	Treat wrist bone fracture.
*25650	Repair writst bone fracture.
26010	Drainage of finger abscess.
26600	Treat metacarpal fracture.
26720	Treat finger fracture, each.
*26725	Treat finger fracture, each.
*26740	Treat finger fracture, each.
28001	Drainage of bursa of foot.
28010	Incision of toe tendon.
*28011	Incision of toe tendons.

ADDENDUM H.—PROCEDURE CODES SUBJECT TO THE SITE-OF-SERVICE DIFFERENTIAL—Continued

HCPCS	Description
*28022	Exploration of a foot joint.
*28024	Exploration of a toe joint.
*28052	Biopsy of foot joint lining.
28108	Removal of toe lesions.
28124	Partial removal of toe.
28126	Partial removal of toe.
28153	Partial removal of toe.
28160	Partial removal of toe.
28190	Removal of foot foreign body.
*28220	Release of foot tendon.
28230	Incision of foot tendon(s).
28232	Incision of toe tendon.
28234	Incision of foot tendon.
28270	Release of foot contracture.
28272	Release of toe joint, each.
*28430	Treatment of ankle fracture.
*28450	Treat midfoot fracture, each.
*28455	Treat midfoot fracture, each.
28470	Treat metatarsal fracture.
28475	Treat metatarsal fracture.
28490	Treat big toe fracture.
*28495	Treat big toe fracture.
28510	Treatment of toe fracture.
28515	Treatment of toe fracture.
*28530	Treat sesamoid bone fracture.
*28540	Treat foot dislocation.
*28570	Treat foot dislocation.
*28600	Treat foot dislocation.
*28630	Treat toe dislocation.
*29015	Application of body cast.
*29020	Application of body cast.
*29025	Application of body cast.
*29035	Application of body cast.
*29049	Application of shoulder cast.
29065	Application of long arm cast.
29075	Application of forearm cast.
29085	Apply hand/wrist cast.
29105	Apply long arm splint.
29125	Apply forearm splint.
29126	Apply forearm splint.
29130	Application of finger splint.
*29131	Application of finger splint.
29200	Strapping of chest.
*29220	Strapping of low back.
29260	Strapping of elbow or wrist.
*29280	Strapping of hand or finger.
29345	Application of long leg cast.
29355	Application of long leg cast.
*29358	Apply long leg cast brace.
29365	Application of long leg cast.
29405	Apply short leg cast.
29425	Apply short leg cast.
29435	Apply short leg cast.
29440	Addition of walker to cast.
*29450	Application of leg cast.
29515	Application lower leg splint.
29520	Strapping of hip.
29540	Strapping of ankle.
29550	Strapping of toes.
29580	Application of paste boot.
*29590	Application of foot splint.
29700	Removal/revision of cast.
29705	Removal/revision of cast.
*29710	Removal/revision of cast.
*29715	Removal/revision of cast.
*29720	Repair of body cast.
*29730	Windowing of cast.
*29740	Wedging of cast.
*29750	Wedging of clubfoot cast.
*29850	Knee arthroscopy/surgery.

ADDENDUM H.—PROCEDURE CODES SUBJECT TO THE SITE-OF-SERVICE DIFFERENTIAL—Continued

HCPCS	Description
*30000	Drainage of lose lesion.
*30020	Drainage of lose lesion.
30100	Intranasal biopsy.
30110	Removal of nose polyp(s).
30200	Injection treatment of nose.
30210	Nasal sinus therapy.
*30220	Insert nasal septal button.
*30300	Remove nasal foreign body.
30901	Control of nosebleed.
31000	Irrigation maxillary sinus.
*31002	Irrigation sphenoid sinus.
*31040	Exploration behind upper jaw.
31505	Diagnostic laryngoscopy.
31575	Diagnostic laryngoscopy.
*31579	Diagnostic laryngoscopy.
*33415	Revision, subvalvular tissue.
*33420	Revision of mitral valve.
*36000	Place needle in vein.
36400	Drawing blood.
*36405	Drawing blood.
*36406	Drawing blood.
*36410	Drawing blood.
*36430	Blood transfusion service.
*36450	Exchange transfusion service.
36470	Injection therapy of vein.
36471	Injection therapy of veins.
*36510	Insertion of catheter, vein.
40490	Biopsy of lip.
*40700	Repair cleft lip/nasal.
*40800	Drainage of mouth lesion.
*40804	Removal foreign body, mouth.
40808	Biopsy of mouth lesion.
40810	Excision of mouth lesion.
40812	Excise/repair mouth lesion.
41100	Biopsy of tongue.
41108	Biopsy of floor of mouth.
*41825	Excision of gum lesion.
*41826	Excision of gum lesion.
42100	Biopsy of roof of mouth.
42330	Removal of salivary stone.
*42400	Biopsy of salivary gland.
42650	Dilation of salivary duct.
*42660	Dilation of salivary duct.
42800	Biopsy of throat.
*43420	Repair esophagus opening.
45300	Proctosigmoidoscopy.
45303	Proctosigmoidoscopy.
45330	Sigmoidoscopy, diagnostic.
*45520	Treatment of rectal prolapse.
46083	Incise external hemorrhoid.
46221	Ligation of hemorrhoid(s).
46230	Removal of anal tabs.
46320	Removal of hemorrhoid clot.
46500	Injection into hemorrhoids.
46600	Diagnostic anoscopy.
46604	Anoscopy and dilation.
*46606	Anoscopy and biopsy.
46614	Anoscopy; control bleeding.
46615	Anoscopy.
46900	Destruction, anal lesion(s).
*46910	Destruction, anal lesion(s).
*46916	Cryosurgery, anal lesion(s).
*46917	Laser surgery, anal lesion(s).
46934	Destruction of hemorrhoids.
*46935	Destruction of hemorrhoids.
46936	Destruction of hemorrhoids.
*46940	Treatment of anal fissure.
*46942	Treatment of anal fissure.
46945	Ligation of hemorrhoids.
*46946	Ligation of hemorrhoids.

ADDENDUM H.—PROCEDURE CODES SUBJECT TO THE SITE-OF-SERVICE DIFFERENTIAL—Continued

HCPCS	Description
51700	Irrigation of bladder.
51705	Change of bladder tube.
51720	Treatment of bladder lesion.
*52265	Cystoscopy & treatment.
*53270	Removal of urethra gland.
53600	Dilate urethra stricture.
53601	Dilate urethra stricture.
53620	Dilate urethra stricture.
53621	Dilate urethra stricture.
53660	Dilation of urethra.
53661	Dilation of urethra.
53670	Insert urinary catheter.
*54050	Destruction, penis lesion(s).
*54055	Destruction, penis lesion(s).
*54056	Cryosurgery, penis lesion(s).
*54200	Treatment of penis lesion.
*54230	Prepare penis study.
54235	Penile injection.
55000	Drainage of hydrocele.
*55250	Removal of sperm duct(s).
*56420	Drainage of gland abscess.
56501	Destruction, vulva lesion(s).
*56606	Biopsy of vulva/perineum.
*57061	Destruction, vagina lesion(s).
57100	Biopsy of vagina.
57150	Treat vagina infection.
57160	Insertion of pessary.
*57170	Fitting of diaphragm/cap.
57452	Examination of vagina.
57454	Vagina examination & biopsy.
*57460	Leep procedure.
57500	Biopsy of cervix.
57505	Endocervical curettage.
57510	Cauterization of cervix.
57511	Cryocautery of cervix.
58100	Biopsy of uterus lining.
*58300	Insert intrauterine device.
*58301	Remove intrauterine device.
*59200	Insert cervical dilator.
*59300	Episiotomy or vaginal repair.
59425	Antepartum care only.
59426	Antepartum care only.
*59430	Care after delivery.
60100	Biopsy of thyroid.
*61000	Remove cranial cavity fluid.
*61001	Remove cranial cavity fluid.
*63690	Analysis of neuroreceiver.
*63691	Analysis of neuroreceiver.
64400	Injection for nerve block.
64405	Injection for nerve block.
*64408	Injection for nerve block.
*64412	Injection for nerve block.
64413	Injection for nerve block.
64418	Injection for nerve block.
*64435	Injection for nerve block.
64440	Injection for nerve block.
64441	Injection for nerve block.
64445	Injection for nerve block.
64450	Injection for nerve block.
64505	Injection for nerve block.
*64508	Injection for nerve block.
64550	Apply neurostimulator.
*64553	Implant neuroelectrodes.
*64555	Implant neuroelectrodes.
*64560	Implant neuroelectrodes.
64565	Implant neuroelectrodes.
*64612	Destroy nerve, face muscle.
*64613	Destroy nerve, spine muscle.
65205	Remove foreign body from eye.
65210	Remove foreign body from eye.

ADDENDUM H.—PROCEDURE CODES SUBJECT TO THE SITE-OF-SERVICE DIFFERENTIAL—Continued

HCPCS	Description
65220	Remove foreign body from eye.
65222	Remove foreign body from eye.
*65286	Repair of eye wound.
65430	Corneal smear.
65435	Curette/treat cornea.
*65436	Curette/treat cornea.
*65600	Revision of cornea.
*65772	Correction of astigmatism.
*65855	Laser surgery of eye.
*65860	Incise inner eye adhesions.
66761	Revision of iris.
*66770	Removal of inner eye lesion.
67145	Treatment of retina.
67210	Treatment of retinal lesion.
67228	Treatment of retinal lesion.
*67345	Destroy nerve of eye muscle.
67505	Inject/treat eye socket.
67515	Inject/treat eye socket.
*67700	Drainage of eyelid abscess.
*67710	Incision of eyelid.
67800	Remove eyelid lesion.
67801	Remove eyelid lesions.
*67805	Remove eyelid lesions.
67810	Biopsy of eyelid.
67820	Revise eyelashes.
67825	Revise eyelashes.
67840	Remove eyelid lesion.
67850	Treat eyelid lesion.
*67915	Repair eyelid defect.
*67922	Repair eyelid defect.
*67930	Repair eyelid wound.
*67938	Remove eyelid foreign body.
68020	Incise/drain eyelid lining.
*68040	Treatment of eyelid lesions.
*68100	Biopsy of eyelid lining.
68110	Remove eyelid lining lesion.
*68135	Remove eyelid lining lesion.
68200	Treat eyelid by injection.
*68400	Incise/drain tear gland.
*68420	Incise/drain tear sac.
68440	Incise tear duct opening.
*68530	Clearance of tear duct.
*68705	Revise tear duct opening.
68760	Close tear duct opening.
68761	Close tear duct opening.
*68770	Close tear system fistula.
68800	Dilate tear duct opening(s).
68820	Explore tear duct system.
68830	Reopen tear duct channel.
68840	Explore/irrigate tear ducts.
69000	Drain external ear lesion.
*69005	Drain external ear lesion.
69020	Drain outer ear canal lesion.
69100	Biopsy of external ear.
*69105	Biopsy of external ear canal.
69200	Clear outer ear canal.
69210	Remove impacted ear wax.

ADDENDUM H.—PROCEDURE CODES SUBJECT TO THE SITE-OF-SERVICE DIFFERENTIAL—Continued

HCPCS	Description
69220	Clean out mastoid cavity.
69222	Clean out mastoid cavity.
69400	Inflate middle ear canal.
69401	Inflate middle ear canal.
*69405	Catheterize middle ear canal.
*69410	Inset middle ear baffle.
69420	Incision of eardrum.
69433	Create eardrum opening.
*69540	Remove ear lesion.
69610	Repair of eardrum.
*69949	Inner ear surgery procedure.
*69979	Temporal bone surgery.
*90749	Immunization procedure.
92002	Eye exam, new patient.
92004	Eye exam, new patient.
92012	Eye exam established pt.
92014	Eye exam & treatment.
*92019	Eye exam & treatment.
92020	Special eye evaluation.
92070	Fitting of contact lens.
92100	Serial tonometry exam(s).
92120	Tonography & eye evaluation.
92130	Water provocation tonography.
92140	Glaucoma provocative tests.
92225	Special eye exam, initial.
92226	Special eye exam, subsequent.
92230	Eye exam with photos.
*92260	Ophthalmoscopy/dynamometry.
*92287	Internal eye photography.
92311	Contact lens fitting.
92312	Contact lens fitting.
*92313	Contact lens fitting.
*92315	Prescription of contact lens.
*92316	Prescription of contact lens.
*92317	Prescription of contact lens.
*92330	Fitting of artificial eye.
*92335	Fitting of artificial eye.
92352	Special spectacles fitting.
92353	Special spectacles fitting.
*92354	Special spectacles fitting.
*92371	Repair & adjust spectacles.
92504	Ear microscopy examination.
92506	Speech & hearing evaluation.
92507	Speech/hearing therapy.
*92508	Speech/hearing therapy.
92511	Nasopharyngoscopy.
*92512	Nasal function studies.
92516	Facial nerve function test.
*92520	Laryngeal function studies.
*92565	Stenger test, pure tone.
*92571	Filtered speech hearing test.
*92575	Sensorineural acuity test.
*92576	Synthetic sentence test.
*92577	Stenger test, speech.
*92582	Conditioning play audiometry.
*93205	Special phonocardiogram.
*93221	Vectorcardiogram tracing.

ADDENDUM H.—PROCEDURE CODES SUBJECT TO THE SITE-OF-SERVICE DIFFERENTIAL—Continued

HCPCS	Description
*93721	Plethysmography tracing.
93797	Cardiac rehab.
93798	Cardiac rehab/monitor.
*95010	Sensitivity skin tests.
*95015	Sensitivity skin tests.
*95056	Photosensitivity tests.
*95065	Nose allergy test.
*95075	Ingestion challenge test.
*95180	Rapid desensitization.
95831	Limb muscle testing, manual.
95832	Hand muscle testing, manual.
95833	Body muscle testing, manual.
95834	Body muscle testing, manual.
95851	Range of motion measurements.
95852	Range of motion measurements.
95857	Tensilon test.
*95880	Cerebral aphasia testing.
*95881	Cerebral developmental test.
96405	Intralesional chemo admin.
96406	Intralesional chemo admin.
*96445	Chemotherapy, intracavitary.
*96450	Chemotherapy, into cns.
*96542	Chemotherapy injection.
*97221	Extended hydrotherapy.
99201	Office/outpatient visit, new.
99202	Office/outpatient visit, new.
99203	Office/outpatient visit, new.
99204	Office/outpatient visit, new.
99205	Office/outpatient visit, new.
99211	Office/outpatient visit, est.
99212	Office/outpatient visit, est.
99213	Office/outpatient visit, est.
99214	Office/outpatient visit, est.
99215	Office/outpatient visit, est.
99241	Office consultation.
99242	Office consultation.
99243	Office consultation.
99244	Office consultation.
99245	Office consultation.
99271	Confirmatory consultation.
99272	Confirmatory consultation.
99273	Confirmatory consultation.
99274	Confirmatory consultation.
99354	Prolonged service, office.
99355	Prolonged service, office.
A2000	Chiropractor manip of spine.
H5300	Occupational therapy.
M0005	Off visit 2/more modalities.
M0006	Off vis 1 modality + 15 min.
M0007	Off vis comb modality 30 min.
M0008	Off vis comb modality 15 min.
M0101	Cutting/remov corns/calluses.

* Proposed addition to the site-of-service list.

[FR Doc. 94–15234 Filed 6–23–94; 8:45 am]
BILLING CODE 4120–01–P