Health Care Financing Administration

[BPD–776–FNC]

RIN 0938–AG27

Medicare Program; Additions To and Deletions From the Current List of Covered Surgical Procedures for Ambulatory Surgical Centers

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

ACTION: Final notice with comment period.

SUMMARY: This final notice with comment period implements section 1833(i)(1) of the Social Security Act, which requires, in part, that the list of covered ambulatory surgical center (ASC) procedures be reviewed and updated at least every 2 years.

This notice announces the specific additions to and deletions from the list of surgical procedures for which facility services are covered when the procedures are performed in a Medicare-participating ASC, as well as the assigned payment groups for each addition. The notice also announces a change in our criteria for deleting procedures from the ASC list. This notice also responds to public comments received in response to our proposed notice published December 14, 1993 (58 FR 65357). In that notice, we requested comments on the proposed additions to and deletions from the list of covered surgical procedures for ASCs; the proposed quantitative change in our deletion criteria; the development of alternatives to the proposed quantitative deletion criteria; and the assignment of payment groups for each addition.

Finally, this notice solicits public comment on certain additions to and deletions from the ASC list that had not been suggested in our December 1993 proposed notice. It also solicits public comment on the assignment of payment groups for certain new procedure codes.

EFFECTIVE DATE: The effective date of this notice is February 27, 1995, except as follows. The effective date for the procedures that are being deleted from the ASC list, as listed in Addendum A, is April 26, 1995.

The effective date for the procedures that were deleted from the list as a result of deletions from the 1992 Physicians' Current Procedural Terminology (CPT), as listed in part 1 of Addendum C, is March 31, 1992. The effective date for the procedures that were added to the list as a result of additions to the 1992 CPT, as listed in part 2 of Addendum C, is January 30, 1992.

The effective date for the procedures that were deleted from the list as a result of deletions from the 1993 CPT, as listed in part 3 of Addendum C, is July 7, 1993. The effective date for the procedures that were added to the list as a result of additions to the 1993 CPT, as listed in part 4 of Addendum C, is January 1, 1993.

The effective date for the procedures that were deleted from the list as a result of deletions from the 1994 CPT, as listed in part 5 of Addendum C, is April 11, 1994. The effective date for the procedures that were added to the list as a result of additions to the 1994 CPT, as listed in part 6 of Addendum C, is January 1, 1994.

COMMENT DATES: We are requesting public comment on the addition of, and assignment of payment groups for, the following new CPT codes, which are listed in Addendum B (since these codes were not suggested in our December 1993 proposed notice): CPT codes 29804, 43259, 51040, 52450, 56309, 56316, 56317, 56351, 56356, and 64421. We are requesting public comment on the appropriateness of the deletion of the CPT codes listed in Addendum C, part 5, and the deletion of CPT code 36522, listed in Addendum A, because these codes were not suggested in our December 1993 proposed notice. Additionally, we are requesting public comment on the appropriateness of the addition of, and assignment of payment groups for, the CPT codes listed in part 6 of Addendum C. Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on March 27 1995.

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–776–FNC, P.O. Box 26688, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (1 original and 3 copies) 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–776–FNC. 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).

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FOR FURTHER INFORMATION CONTACT: Jackie Sheridan, (410) 966–4635 for Additions or Deletions. Joan Sanow, (410) 966–5723 for Payment Groups.

SUPPLEMENTARY INFORMATION:

I. Background

Section 934 of the Omnibus Reconciliation Act of 1980 (Public Law 96–499), enacted on December 5, 1980, amended sections 1832(a)(2) and 1833 of the Social Security Act (the Act) to authorize the Secretary to provide benefits for services furnished in an ambulatory surgical center (ASC). Section 1833(i)(1) of the Act requires the Secretary to specify, in consultation with appropriate medical organizations, surgical procedures that, although appropriately performed in an inpatient hospital setting, can also be performed safely on an ambulatory basis. The report accompanying the legislation explained that the Congress intended that procedures currently performed on an ambulatory basis in a physician's office, which do not generally require the more elaborate facilities of an ASC, should not be included in the list of covered procedures (H.R. Rep. No. 1167, 96th Congress, 2d Session 390 (1980), *reprinted* in 1980 U.S.C.C.A.N. 5526, 5753).

On August 5, 1982, we published a final rule in the **Federal Register** (47 FR 34094) to establish Medicare coverage for ASC services at 42 CFR part 416. These regulations were amended on November 14, 1986 (51 FR 41351), June 12, 1987 (52 FR 22454), and April 7, 1988 (53 FR 11508). We implement the

provision requiring the Secretary to publish a list of procedures covered in an ASC through issuance of periodic notices in the **Federal Register**.

Section 9343 of the Omnibus Budget Reconciliation Act of 1986 (OBRA '86) (Public Law 99–509), enacted on October 21, 1986, amended section 1833(i)(1) of the Act to require that the ASC list of procedures be reviewed and updated by April 21, 1987, and not less often than every 2 years thereafter. As a result, we published updates in the **Federal Register** on April 21, 1987 (52 FR 13176), June 1, 1989 (54 FR 23540), and December 31, 1991 (56 FR 67666). These updates supplement the original list of covered ASC procedures published on August 5, 1982 (47 FR 34099).

In line with the Congressional intent, current regulations (42 CFR 416.65(a)) list the following general requirements regarding the range of covered ASC services:

- Procedures on the list are commonly performed on an inpatient basis but, consistent with accepted medical practice, also may be performed in an ASC.
- The list excludes procedures that are commonly performed, or may be safely performed, in a physician's office.
- Procedures are limited to those requiring a dedicated operating room and generally do not require an overnight stay.
- The list does not contain procedures excluded from Medicare coverage.

In addition, current regulations (§ 416.65(b)) list the following specific requirements:

- Covered surgical procedures are limited to those that do not generally exceed—
  + A total of 90 minutes operating time; and
  + A total of 4 hours recovery or convalescent time.
- If the covered surgical procedures require anesthesia, the anesthesia must be—
  + Local or regional anesthesia; or
  + General anesthesia of 90 minutes or less duration.
- Covered surgical procedures may not be of a type that—
  + Generally result in extensive blood loss;
  + Require major or prolonged invasion of body cavities;
  + Directly involve major blood vessels; or
  + Are generally emergency or life-threatening in nature.

Currently, ASC covered procedures are classified according to an eight group payment classification system, as follows:

Group 1—$295
Group 2—$395
Group 3—$453
Group 4—$558
Group 5—$637
Group 6—$750 ($600+$150)
Group 7—$883
Group 8—$880 ($730+$150)

(The $150 payment allowance in Groups 6 and 8 is for intraocular lenses (IOLs).) A ninth payment group allotted exclusively to extracorporeal shock wave lithotripsy (ESWL) services was established in the notice with comment period published December 31, 1991 (56 FR 67666). The decision in *American Lithotripsy Society v. Sullivan*, 785 F. Supp. 1034 (D.D.C. 1992) prohibits us from paying for these services under the ASC benefit at this time. ESWL payment rates are the subject of a separate **Federal Register** proposed notice, which was published October 1, 1993 (58 FR 51355).

The ASC facility payment for all procedures in each group is established at a single rate adjusted for geographic variation. This prospectively determined facility group rate does not include physicians' fees and other medical items and services (for example, prosthetic devices, except IOLs) for which separate payment is authorized under other provisions of the Medicare program. Rather, the rate is a standard overhead amount that covers the cost of services such as nursing, supplies, equipment, and use of the facility.

Section 9343 of OBRA '86 amended section 1833(i)(2)(A) of the Act to require updating of the ASC payment rates annually beginning no later than July 1, 1987. In addition, so that the most current wage index values can be used in determining payment amounts for ASC facility services, annual ASC payment rate updates are implemented concurrently with the annual update of the inpatient hospital prospective payment system (PPS) wage index published in the **Federal Register**.

Section 13531 of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) (Public Law 103–66), enacted on August 10, 1993, prohibited the Secretary from providing for any inflation update in the ASC payment rates for fiscal year 1995. In addition, the legislation reduced the allowance for an IOL furnished during or subsequent to cataract surgery performed in an ASC from $200 to $150 beginning January 1, 1994, and before January 1, 1999. As a result, the payment rates and the $150 payment allowance for an IOL in Groups 6 and 8 will remain the same in fiscal year 1995.

In our December 1991 notice, we stated that changes in ASC payment rates and the list of ASC covered procedures would be implemented concurrently during the years in which both are updated (56 FR 67677). The ASC payment rates and the ASC procedure list were updated concurrently for the first time effective for ASC services furnished beginning December 31, 1991. Because of the OBRA '93 freeze on the ASC payment rates for fiscal year 1995, the ASC payment rate update notice will not be published this year although we will instruct our carriers to adopt the fiscal year 1995 hospital inpatient PPS wage index, published in the **Federal Register** on September 1, 1994 (59 FR 45330), to adjust payment rates for regional wage differences.

II. Provisions of the Proposed Notice

In the proposed notice, which was published December 14, 1993 (58 FR 65357), we proposed specific procedures for addition to or deletion from the ASC list. These proposed changes were the result of our consideration of data on site of service from the National Claims History File (NCHF) and general correspondence received from the public and medical community over the few years preceding publication of the proposed notice. (The NCHF is a database maintained by our Bureau of Data Management and Strategy. The data in the NCHF are derived from 100 percent of the Medicare Part A and Part B claims processed.) For each proposed addition, we proposed a payment group based on payment rates for codes on the existing ASC list, and in the same Physicians' Current Procedural Terminology (CPT) grouping, that are similar in surgical method and resource consumption. (The CPT is published annually by the American Medical Association.)

With the advice of our medical staff, we proposed to add surgical procedures that are performed in ASCs and meet certain standards contained in existing regulations. We also proposed to modify our criteria for deleting procedures from the ASC list. As the practice of medicine has changed over the years, procedures that were at one time commonly performed on an inpatient basis gradually have shifted to the hospital outpatient department (OPD) as the most common site of service, and a few eventually have shifted to the physician's office as the primary site of service. Procedures that are not performed on an inpatient basis or are primarily performed in a physician's

office no longer meet the conditions specified in regulations. This development results in a corresponding change in claims data to lower inpatient and higher physician's office site-of-service performance percentages, and these procedures no longer meet our 20/50 site-of-service criteria. By 20/50 site-of-service criteria, we mean that if a procedure is performed on an inpatient basis 20 percent of the time or less, or in a physician's office 50 percent of the time or more, it should not be covered when performed in an ASC. We may make exceptions and override the criteria if we believe the data are inaccurate or if there are medical reasons to override the data.

If we had strictly applied the 20/50 criteria to our current ASC list without making exceptions, we would have been proposing deletion of a number of procedures, such as cataract removal, that we believe are appropriate to the ASC setting. We were also concerned with what might be termed a ''ping-pong'' situation; that is, adding a procedure during one update with 49 percent physician's office performance and then deleting it during the next update if it reached 51 percent physician's office performance. Consequently, we proposed the following criteria for deleting a procedure from ASC coverage: The combined inpatient, OPD, and ASC site-of-service percentage is less than 46 percent of the total volume; and either—

- The procedure is performed 50 percent of the time or more in a physician's office; or
- The procedure is performed 10 percent of the time or less in an inpatient hospital setting.

This proposed change would allow the site of service for procedures in the physician's office to grow from below 50 percent (when it is added) to as high as 54 percent, as long as the percentage of time the procedure is performed in a facility with a dedicated operating room remains at 46 percent. Similarly, the criteria allow procedures to move from an inpatient hospital site of service to an OPD site of service and still remain on the ASC list. To determine whether a procedure should be *added* to the ASC list, we indicated that we would continue to use the 20/50 site-of-service criteria.

We incorporate annual revisions of the CPT into our list of procedures covered in an ASC. Therefore, we also proposed for public comment the procedure codes that were added to or deleted from the ASC list through changes to the Medicare Carriers Manual as a result of updates of the 1992 and 1993 editions of the CPT.

In addition, we proposed to remove from the ASC list five CPT codes that involve procedures relating to the usage of implantable infusion pumps not covered by Medicare.

III. Analysis of and Responses to Public Comments

In our December 1993 proposed notice, we requested comments on the proposed quantitative change in our deletion criteria; the development of alternatives to the proposed quantitative deletion criteria; proposed additions to and deletions from the ASC list; and the assignment of payment groups for each addition. In response, we received 558 timely public comments from 191 urologists, 107 ASCs, 52 anesthesiologists, 50 patients, 30 ophthalmologists, 26 psychiatrists, 28 plastic surgeons, 14 obstetrician/gynecologists, 8 gastroenterologists, 6 dermatologists, 19 professional/medical societies, and 27 others (that is, neurologists, attorneys, radiologists, a Medicare director, a podiatrist, an accountant, otolaryngologists, a supplier, and an oncologist). A summary of these comments and our responses to them follows:

Criteria for Determining Procedures for Coverage in an ASC

In our December 1993 proposed notice, we announced our intention to apply alternative utilization threshold criteria for deleting procedures from ASC coverage. That is, rather than deleting procedures that fall below the current coverage threshold, we proposed alternative criteria for deleting procedures that examine the incidence of dedicated operating room use (combined ASC, OPD, and inpatient site-of-service utilization) in determining if a procedure that has dropped below the 20 percent inpatient criteria should remain covered in an ASC. We specifically solicited comments on the alternative criteria. However, we did not receive any comments on this issue.

In addition, we requested comments on developing alternatives to the quantitative criteria we currently use in developing the ASC list. We received 64 comments regarding our current site-of-service-based criteria. The commenters included 35 ASCs, 16 urologists, 4 anesthesiologists, and 9 professional societies.

Comment: Several commenters stated that our criteria are outdated, reflecting a period when surgery was rarely performed on an outpatient basis. They noted an absence of scientific or medical literature supporting the thresholds used. Therefore, they believed the criteria are arbitrary.

Response: The inpatient and physician's office utilization thresholds serve as a reasonable interpretation of the statutory language ''appropriately performed on an inpatient basis.'' That is, we believe that if a procedure is performed at least 20 percent of the time on an inpatient basis and no more than 50 percent of the time in a physician's office, we can reasonably regard the procedure as appropriate to the inpatient setting. Section 1833(i)(1) of the Act requires the Secretary to ''specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis'' in an ASC. Thus, section 1833(i)(1) of the Act is clear that procedures included on the ASC list of covered procedures must be those that are appropriately performed on an inpatient basis.

In developing regulations that implemented section 1833(i)(1) of the Act, we prepared the criteria set forth at 42 CFR 416.65 (''Covered surgical procedures''). Those regulations specify conditions for coverage of procedures that are commonly performed on an inpatient basis but may be safely performed on an outpatient basis. These conditions include requirements such as operating room time not exceeding 90 minutes, recovery period not exceeding 4 hours, limited blood loss, and limited invasion of body cavities. We believe that these criteria reasonably meet the conditions set forth in the legislation.

For several years, we used only the qualitative criteria described in the regulations. We added procedures to the list based on physicians' review of procedures recommended by medical organizations. This system resulted in only a limited number of procedures being added to the ASC list.

Patient variability made it difficult for our physicians to accurately determine procedures that should be added to the list, especially procedures that are close to the cut-off of the qualitative criteria; for example, a surgery time of 2 hours or a recovery time of 4½ hours. A given procedure varies with patient condition. That is, a procedure that may be accomplished in 90 minutes for one patient may take 120 minutes for another.

In developing the 1987 update of the ASC list, we determined that a numerical threshold based on site of service should be used to assist us in implementing section 1833(i)(1) of the

Act. We believed criteria based on site of service, as shown in our current claims data, would yield a range of procedures for review by our staff of physicians to include on the ASC list. In this way, we would have support for the addition of procedures physicians generally perform on an inpatient basis. Our physicians then review the complete list of procedures that meet the threshold criteria and determine which meet the qualitative criteria in our regulations.

We acknowledge that utilization of outpatient surgical settings has increased considerably since we first initiated the threshold criteria in 1987. For this reason, we proposed altering the criteria for deleting procedures from the ASC covered procedures list. We thus recognize some movement to the outpatient setting without eliminating coverage. However, once a procedure is performed in a physician's office the majority of the time and does not require the setting of an ASC, OPD, or inpatient hospital 46 percent of the time, we believe that section 1833(i)(1) of the Act requires that we delete ASC coverage of the procedure.

When preparing the December 1993 proposed notice, we considered policy alternatives and discussed reverting to physician judgment exclusively. However, we believe that this option is too subjective, leaving policy decisions solely to the discretion of a few. If we were challenged by another physician's opinion, we could be presented with the situation of two equally qualified professionals with different opinions. Thus, we believe that some objective criteria are essential in determining coverage of procedures in an ASC.

Comment: Some commenters believed that the Common Working File (CWF) is inadequate for assessing site of service. (The CWF is a Medicare Part A and Part B benefit coordination and prepayment claims validation system that uses localized databases maintained by designated carriers. The CWF indicates site of service for surgical procedures.) The commenters believed that the data produced are skewed, especially for periods before the last 2 years when site-of-service data had been emphasized. They stated that CPT coding practices vary greatly, resulting in the same procedure being coded differently in different areas.

Response: We acknowledge that the early data using site-of-service codes contained errors. Those data may have skewed results, particularly for low-volume procedures or procedures near the threshold levels. Consequently, our criteria allow for exceptions if the data appear flawed, or our physicians, after consultation with medical societies and local experts, believe a procedure is appropriate to the inpatient setting despite the data. Under this exceptions authority, we have retained procedures such as cataract extractions, which have not met the inpatient criterion for several years. In addition, the public has an opportunity to comment, through our rulemaking process, on what they believe are errors in the data.

With regard to the issue of varying CPT coding practices, we acknowledge that not all physicians code a particular procedure identically. Unfortunately, this variation in coding is often the result of an attempt to maximize Medicare payment to the physician for the procedure, rather than the result of ambiguous coding guidelines. While this upcoding occasionally affects the ASC list, we attempt to identify these situations and retain the procedure on the ASC list through the exceptions authority if the procedure is appropriate to the inpatient setting. We ask physicians to encourage their peers to code procedures appropriately to avoid these situations.

Comment: One commenter believed we should use a 10 percent inpatient criterion for adding procedures to the list. The commenter also suggested that any procedure generally requiring the prior or concurrent administration of general, spinal, or regional anesthesia, or of sedation or analgesia sufficient to compromise a patient's protective reflexes, be included on the ASC list regardless of utilization data.

Response: The type of anesthesia necessary for a given procedure varies among patients. Some patients have very low pain thresholds, special psychological needs, or anatomical conditions warranting a higher level of anesthesia than others. We encourage every physician to use his or her judgment in selecting the appropriate anesthesia. We do not encourage the use of anesthesia in settings not appropriately equipped for emergency situations.

The need for an operating room setting for a particular patient is not equivalent to a procedure meeting the conditions of section 1833(i)(1) of the Act for ASC coverage. As discussed above, section 1833(i)(1) requires that we cover procedures in an ASC only if they are appropriately performed on an inpatient basis. Thus, if a patient requires a higher degree of anesthesia than is reflected in the utilization data, that procedure would be covered in an OPD, or, if necessary, in an inpatient hospital setting.

We had considered revising the criterion for adding procedures on the ASC list to 10 percent inpatient utilization. However, we believe that the current threshold of 20 percent represents a reasonable portion of use necessary to meet the statutory requirement of appropriately performed on an inpatient basis.

Comment: One commenter believed that our physician's office threshold should focus on the percentage of physicians performing the procedure in the office, rather than the percentage of procedures being performed in the office.

Response: We do not believe that the percentage of physicians performing a procedure in their offices, rather than the total site-of-service utilization data, is preferable for determining ASC coverage. Many physicians perform a given procedure only once or twice during the year. These physicians are not likely to maintain the specialized equipment necessary to perform the procedure in their offices, and, therefore, are not likely to perform it in that location. Also, a particular physician may not be proficient with the procedure and may desire to perform the procedure where there are resources available, should a mishap occur.

We do not believe that a large percentage of physicians performing a few procedures should serve as the basis for determining whether a procedure meets the conditions of section 1833(i)(1) of the Act. It is difficult to ignore the data indicating a procedure is commonly performed in a physician's office, if only relatively few physicians perform the majority of the procedures, in favor of those physicians performing the same procedure on an occasional basis. In addition, accurately determining the percentage of physicians performing a procedure in their offices would be extremely difficult.

Comment: One commenter believed that the criteria result in a competitive advantage to an OPD over an ASC. The commenter recommended that if a procedure can be safely performed in an OPD, it can be safely performed in an ASC and should be on the list.

Response: Section 1833(i)(1) of the Act established criteria for coverage in an ASC when the ASC services were added as a Medicare benefit in 1980. Section 1833(i)(1) of the Act requires that we develop a list of procedures covered in an ASC and base the list on procedures that are appropriately performed on an inpatient basis.

These requirements for ASC coverage are not applicable to an OPD. The original Medicare statute provided for coverage of all services furnished by an

OPD, but it did not provide for any limitations on the appropriateness of a procedure for the inpatient setting or for the establishment of a list of procedures. Consequently, it is reasonable to expect that procedures covered in an OPD will not always be the same as procedures covered by section 1833(i)(1) of the Act. For example, there is no limitation on an OPD to perform only surgical procedures. Thus, adopting the suggestion would result in a significant expansion of the ASC benefit beyond that contemplated in section 1833(i)(1).

Comment: One commenter believed that operating and recovery time usage are inaccurate indicators of the complexity of procedures, and clinical criteria should be used instead. The commenter stated that the overriding guideline should be that the patient can return home by the close of the business day.

Response: We recognize the commenter's concern that clinical criteria be considered in establishing the ASC list. However, we believe that general operating and recovery times are related to clinical criteria. That is, we do not look at operating and recovery room times on an isolated basis, but rather review the clinical information indicating that generally patients require 90 minutes or less operating time and 4 hours or less recovery time. We believe that these criteria are good indicators of a patient's ability to go home by the close of the business day. Procedures requiring longer times than those included in the criteria are unlikely to be completed within the business day. For example, we would expect that patients arrive at least 1 hour before the surgery begins. Thus, our criteria involve 6½ hours of an 8 hour work day, allowing 1½ hours leeway for any delays.

Comment: Some commenters believed that the Medicare program should allow for overnight stays in an ASC. The commenters stated that, initially, the inclusion of overnight stays could be part of a study with a Medicare review at the annual certification survey or a review by the Peer Review Organization (PRO).

Response: Section 1833(i)(i) of the Act provides for coverage of surgical procedures that, in addition to other criteria, ''can be performed safely on an ambulatory basis.'' We believe section 1833(i)(1) is clear that coverage of overnight stays under the ASC benefit is prohibited. Rather, ambulatory care implies care that is furnished with the patient going home by the end of the day. Thus, it would require a legislative change to extend Medicare ASC benefits to overnight care or recovery care.

Our Office of Research and Demonstrations has the authority to waive certain portions of the statute in order to study alternative means of furnishing or paying for services under the Medicare program. We solicit research proposals annually through a notice published in the **Federal Register**, and projects are selected on a competitive basis. ASCs are welcome to submit their research proposals for consideration under the routine solicitation process.

Comment: One commenter suggested that Medicare develop an alternative list of procedures that could be covered in an ASC upon precertification from the fiscal intermediary or the PRO. Another commenter suggested we establish ''severity levels'' that allow physician discretion for procedures and settings. The commenter believed that, as certain CPT codes are deleted from the list, the codes should continue to justify a facility fee if certain ''severity levels'' and health risks apply. The same commenter stated that these codes can be billed with a modifier or with the accompanying International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) diagnostic codes explaining the patient's condition. Yet a third commenter suggested that an ASC site of service could be justified by evaluating certain parameters. The commenter believed that an outpatient setting, rather than a physician's office, would be appropriate if certain conditions, such as intravenous therapy or expensive equipment, are involved.

Response: For a procedure to be covered in an ASC, the procedure must meet the conditions set forth in section 1833(i)(1) of the Act. That is, procedures covered in an ASC must be appropriately furnished on an inpatient basis but also can be performed safely on an ambulatory basis.

There are some patients who, because of medical conditions, may require surgery in an ASC-like setting, that is, a dedicated operating room with a recovery area and emergency equipment, etc. Although some patients may require this setting because of health status, the procedure may still not meet the conditions for ASC coverage set forth in section 1833(i)(1) of the Act. That is, a procedure that is routinely performed in a physician's office is still not appropriate for the inpatient setting, although an occasional patient requires hospitalization for the procedure. Precertification of the specific needs of the patient does not make the procedure inpatient. Rather, it means that a particular physician attests that a patient requires a more intensive setting for the procedure.

Moreover, there are no commonly accepted severity levels that we could easily accommodate in the development of the list of covered procedures for ASCs. Section 1833(i)(1) of the Act does not provide for an evaluation of individual patient conditions, such as severity, in the development of the ASC list. The list is required to reflect common practices. We would not expect physicians to perform procedures in offices not adequately equipped for the procedure. These cases should be handled in an OPD if the procedure is not on the ASC list.

Comment: One commenter stated that we should be aware that our ASC list is used by virtually all Medicaid programs in the U.S., as well as private insurers.

Response: The Medicare ASC list is not intended to be a list of all procedures performed in an ASC. Rather, it is a list of procedures that meet the requirements of section 1833(i)(1) of the Act. When we develop our list, we consider section 1833(i)(1) and the appropriateness of a given procedure for the Medicare population. For example, our list contains no pediatric procedures. Yet these procedures would be appropriate for Medicaid patients.

The Medicare program cannot be responsible for the actions of third party payers. Any programs that have decided to adopt our list should do so with appropriate modifications, keeping in mind the limitations of section 1833(i)(1) of the Act and the requirements of their customers.

Comment: Another commenter requested that we consider a list of approved procedures and minor surgeries that can be safely performed in a physician's office. The commenter believed that this list should contain no procedures requiring anesthesia or sedation of any kind.

Response: We do not believe it is appropriate to develop a list of procedures that can safely be performed in physicians' offices. Physicians' offices vary significantly in equipment and staffing. We have not established standards for physicians' offices, nor do we survey them. Because there is broad variability in these offices, the development of a list is likely to result in the exclusion of procedures that are safely performed in some locations and the unfair restriction of physicians' practices. We believe that physicians will not perform a procedure in their offices unless they maintain appropriate facilities, equipment, and staff to perform the procedure safely.

Additions to the List

The proposed list of additions in our December 1993 proposed notice received no negative comments. The few comments we received were positive and were written as an introduction to letters opposing our proposed deletions.

Additional Suggestions for Coverage

We received several comments recommending coverage for procedures not proposed for addition to the list. Some comments included procedures we addressed in the December 1993 proposed notice as having been previously considered. The following section, arranged by body system, responds to those comments.

Integumentary System

Comment: Some commenters proposed the addition of the following procedures to the list:

CPT Code	Description
15820	Blepharoplasty, lower eyelid.
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad.
18522	Blepharoplasty, upper eyelid.
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid.

Response: We proposed to add these procedures to the ASC list in 1991. Based on our review of the public comments and the advice of our medical staff, we decided not to add these procedures to the list because they are commonly performed for cosmetic purposes. Section 1862(a)(10) of the Act prohibits payment for cosmetic surgery or expenses incurred in connection with cosmetic surgery. We recognize that there are circumstances when surgery on the eyelids is performed for noncosmetic reasons; for example, impairment of vision. Often these circumstances require a more complex procedure than a simple blepharoplasty. For that reason, we include on the ASC list all of the blepharoptosis repair codes (CPT codes 67901 through 67908). These procedures are performed less commonly for cosmetic purposes than the blepharoplasty codes.

We also reviewed the most recent data regarding site of service and noted that the blepharoplasty procedures are performed infrequently on an inpatient basis (3 to 5 percent of blepharoplasty procedures are performed on an inpatient basis). In light of this and our concern about the cosmetic nature of the procedures, we have decided against adding CPT codes 15820 through 15823 to the ASC list.

Comment: Commenters proposed the following procedures for the ASC list. All of these procedures involve removal of various size skin lesions from different anatomical locations. They are CPT codes 11400 through 11403, 11420 through 11423, 11440 through 11443 (all of which involve excision of benign skin lesions); and CPT codes 11600 through 11603, 11620 through 11623, and 11640 through 11643 (all of which involve excision of malignant skin lesions).

Response: A review of our billing data indicates that all these procedures are performed in the physician's office from 70 percent to 91 percent of the time, with most of the procedures performed 80 percent of the time in the physician's office setting. They are therefore appropriate to the physician's office and not the ASC.

Comment: One commenter proposed the following codes for addition to the ASC list:

CPT Code	Description
19200	Mastectomy, radical, including pectoral muscles, axillary lymph nodes.
19220	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation).

Response: These procedures involve axillary node dissection. After consultation with physicians in the community, our medical staff believe these procedures do not meet the ASC criteria. Surgical time frequently exceeds the 90 minutes specified for ASCs in § 416.65(b)(1)(i). In addition, since these procedures have potential for greater complications, they generally require more observation time than the 4 hours specified for inclusion on the ASC list in § 416.65(b)(1)(ii). We believe these procedures are appropriately performed on an inpatient basis, and our data indicate they are both performed 90 percent of the time in the inpatient setting. Therefore, we are not adding them to the ASC list.

Comment: Commenters proposed addition of the following codes:

CPT Code	Description
19162	Mastectomy, partial; with axillary lymphadenectomy.
19240	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle.

Response: Our billing data indicate that CPT code 19162 is performed on an inpatient hospital basis 78 percent of the time, and CPT code 19240 is performed on an inpatient hospital basis 92 percent of the time. In addition, CPT code 19162 requires longer than the 4-hour recovery time requirement, and CPT code 19240 requires longer than the 90-minute operating time requirement for ASC coverage set forth at § 416.65(b)(1)(i). Therefore, they fail to meet our criteria for coverage in an ASC.

Musculoskeletal System

Comment: One commenter suggested the addition of the following codes to the ASC list:

CPT Code	Description
22110	Partial excision of vertebrae (eg, for osteomyelitis); cervical.
22114	Partial excision of vertebrae (eg, for osteomyelitis); lumbar.

Response: CPT code 22110 is performed 80 percent of the time on an inpatient basis; and CPT code 22114, 94 percent. CPT codes 22110 and 22114 are not appropriate for the ASC setting because the procedures require extensive dissection and a recovery time of more than 4 hours.

Comment: One commenter proposed CPT code 29848 (arthroscopy, wrist with release of transverse carpal ligament) for addition to the ASC list.

Response: CPT code 29848 is performed 8 percent of the time on an inpatient basis and does not meet our 20 percent inpatient criterion.

Respiratory System

Comment: One commenter proposed the addition of the following codes to the ASC list:

CPT Code	Description
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure).
31233	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture).
31235	Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of osteum).

Response: CPT codes 31233 and 31235 were replacement codes to codes previously on the ASC list. They were cross-referred from existing codes in the 1994 CPT, and both have been added to the list by our manual instructions. (These procedures are listed in Addendum C, part 6, at the end of this notice.) We are not adding CPT code 31231 to our list because it replaced

CPT code 31250. This procedure was performed 90 percent of the time in the physician's office setting, thus failing to meet our criterion for inclusion on the ASC list.

Digestive System

Comment: Two commenters proposed the following codes for addition to the ASC list:

CPT Code	Description
43030	Cricopharyngeal myotomy.
43830	Gastrostomy, temporary (tube, rubber or plastic) (separate procedure).

Response: CPT code 43030 is performed 79 percent of the time on an inpatient basis, and CPT 43830 is performed 90 percent of the time on an inpatient basis. There is concern about complications with these procedures, and both also require a 23-hour observation period before discharge. They are therefore not appropriate to the ASC list.

Comment: Commenters proposed adding the following 19 gastrointestinal endoscopy codes that were new CPT codes January 1, 1994: CPT codes 43205, 43216, 43244, 43248, 43250, 43259, 43261, 43458, 44365, 44376, 44377, 44378, 44394, 44500, 45308, 45309, 45338, 45339, and 45384. Some of the codes involved editorial changes of existing CPT procedures, and some were new CPT procedures.

Response: We have added 12 of these 19 gastrointestinal codes to the ASC list by our manual instructions. They are CPT codes 43216, 43248, 43250, 43261, 43458, 43465, 44394, 45308, 45309, 45338, 45339, and 45384. These 12 CPT codes with their descriptions are listed in Addendum C, part 6, at the end of this notice. We were able to cross-refer CPT codes deleted from our ASC list (which were identified in Appendix B of the 1994 CPT, a summary of additions, deletions, and revisions applicable to CPT 1994 codes) to these 12 codes. These codes were replacement codes to codes previously on the ASC list. They were cross-referred from existing codes in the 1994 CPT and have been added to the list by our manual instructions.

With this notice, we are also adding from Appendix B of the CPT another code that meets our criteria, CPT code 43259 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination). We are not, however, adding CPT codes 43205 (Esophagoscopy, rigid or flexible; with band ligation of esophageal varices) and 43244 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices) because the treatment of varices risks complications of severe, sudden bleeding, which may require an immediate blood transfusion or the introduction of a special tube to control the bleeding. These remedies would not necessarily be available as quickly in the ASC setting. If complications develop, the patient might require air evacuation to the hospital setting. Also, the medical community does not fully accept the use of band ligation in the treatment of varices because its success and comparison to the standard treatment is yet to be completed.

We are not adding the following CPT codes to the ASC list:

CPT Code	Description
44376	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure).
44378	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding, any method.
44500	Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure).

These procedures require that an endoscopy tube be passed through the gastrointestinal system while the patient waits 4 to 6 hours before the physician performs the endoscopic study. The patient would need to be in the ASC from 6 to 10 hours. We believe that this extended time period for the procedure exceeds the spirit, if not the letter, of the regulations set forth at § 416.65(b), which establish 5 1/2 hours as a maximum procedure/recovery time. In conclusion, our medical consultants have determined that CPT codes 43205, 53244, 44376, 44378, and 44500 are not appropriate for Medicare patients in the ASC setting.

Comment: Commenters proposed adding CPT code 45330 (flexible sigmoidoscopy) to the ASC list.

Response: This procedure is performed 73 percent of the time in the physician's office and is appropriate to that setting. Therefore, it does not meet the criteria for the ASC list and will not be added.

Urinary System

Comment: One commenter recommended CPT code 51040 (cystostomy tube replacement) for addition to the ASC list.

Response: This procedure meets our criteria and will be added to the ASC list (see Addendum B).

Comment: One commenter proposed CPT code 51715 (injection of implant material into the urethra) for addition to the ASC list.

Response: CPT code 51715 is a new CPT code effective January 1, 1994. This procedure was previously coded as ''unlisted'' and was not covered under any other procedure on the ASC list. Our medical staff are knowledgeable of this procedure, and we therefore do not require a year of billing data to make a determination. Our medical staff advise us that this is a physicians' office procedure, and it is not appropriate to add it to the ASC list.

Comment: One commenter suggested CPT code 51845 (abdomino-vaginal vesical neck suspension) for addition to the ASC list.

Response: CPT code 51845 is performed on an inpatient basis 92 percent of the time. Generally, there is also a 23-hour observation period before discharge. Thus, it exceeds our criterion for the 4-hour recovery time in § 416.65(b)(1)(ii). We are, therefore, not adding it to the ASC list.

Comment: Commenters proposed CPT code 52450 (transurethral incision of prostate) for addition to the ASC list.

Response: CPT code 52450 is performed 1 percent of the time in a physician's office and 70 percent of the time on an inpatient basis. It thus meets our criteria and will be added to the ASC list.

Comment: Commenters proposed the addition to the ASC list of CPT code 52601 (transurethral resection of the prostate (TURP)) when a laser is used.

Response: CPT code 52601 does not specify use of a laser in its coding description. Thus, the code represents TURPs done by all methods, and it is not possible to identify those performed by laser. CPT code 52601 is commonly performed on an inpatient basis with a 94 percent inpatient hospital site of service. Most cases require over 4 hours recovery time, and, thus, the procedure does not meet our criteria for coverage in an ASC in § 416.65(b)(1)(ii). Should the CPT develop a new laser TURP code, we would consider this procedure's appropriateness in the ASC.

Male Genital System

Comment: One commenter suggested the addition of radioactive seed implantation to treat prostate cancer.

Response: There is presently no single surgical procedure code in the CPT describing this procedure and

consequently no billing data to determine site of service. We are uncertain which code or codes the commenter is using when performing this procedure, but we understand the procedure is often used in conjunction with a radiology code. Radiology codes cannot be included in our ASC list because the ASC list is restricted to surgical codes in the surgery section of the CPT.

Comment: Commenters proposed the addition of the following codes:

CPT Code	Description
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid).
54401	Insertion of penile prosthesis; inflatable (self-contained).
54405	Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir.
54407	Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders.

Response: When we previously solicited public comment on penile prostheses implant procedures, we received comments unanimously opposed to the addition of these codes to the list. Commenters indicated that these procedures were inappropriate for the Medicare population in the ASC setting. The procedure recovery time exceeds the 4-hour limit, the maximum allowed for coverage in an ASC. Surgeons performing these procedures reported a recovery time of 24 to 72 hours.

We have given careful consideration to adding these procedures, based on the new comments we received favoring their addition. One commenter, who previously had written in strong opposition, stated that penile prostheses implants should be added to the list since some patients recover in less than 24 hours. Since our regulations indicate a 4-hour recovery limit, we have determined that these procedures remain inappropriate for the Medicare population in an ASC and should not be added to the list.

Laparoscopy/Peritoneoscopy/ Hysteroscopy

Comment: One commenter proposed the following codes for addition to the ASC list:

CPT Code	Description
56308	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy).
56309	Laparoscopy, surgical; with removal of leiomyomata subserosal (single or multiple).

Response: CPT code 56308 is performed on an inpatient basis 91 percent of the time. This procedures involves cutting a hole in the pelvis floor and the severing of major arteries and veins. It also requires longer than 4 hours recovery time. We are therefore not adding it to the ASC list. CPT code 56309 meets our criteria and will be added to the list (see Addendum B).

Comment: Commenters wrote proposing that the following laparoscopic cholecystectomy procedure codes be added to the ASC list (21 commenters for CPT code 56340, 18 for CPT code 56341, and 17 for CPT code 56342, respectively):

CPT Code	Description
56340	Laparoscopy, surgical; cholecystectomy (any method).
56341	Laparoscopy, surgical; cholecystectomy with cholangiography.
56342	Laparoscopy, surgical; cholecystectomy with exploration of common duct.

Response: The medical information available indicates laparoscopic cholecystectomy usually requires a 23-hour observation period or an inpatient stay, and, therefore, exceeds the 4-hour recovery time requirement in § 416.65(b)(1)(ii). Therefore, we are not adding it to the list.

Comment: Commenters also proposed the addition of the following codes to the ASC list:

CPT Code	Description
56316	Laparoscopy, surgical; repair of initial inguinal hernia.
56317	Laparoscopy, surgical; repair of recurrent inguinal hernia.

Response: These procedures meet our criteria and will be added to the list (see Addendum B).

Comment: One commenter proposed the following codes for addition to the ASC list:

CPT Code	Description
56351	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C.
56356	Hysteroscopy, surgical; with endometrial ablation (any method).

Response: These procedures meet our criteria and will be added to the list (see Addendum B).

Nervous System

Comment: Commenters proposed that we add to the ASC list the following nerve injection codes: CPT codes 62298, 64400, 64402, 64405, 64408, 64412, 64413, 64418, 64425, 64435, 64440, 64441, 64445, 64450, 64505, and 64508.

Response: According to our claims data, most of these procedures are performed less than 20 percent of the time on an inpatient basis and over 50 percent of the time in a physician's office (most being performed over 70 percent of the time in a physician's office). The exceptions are CPT codes 62298 and 64425, which meet the physician's office criterion but are performed less than 20 percent of the time in the inpatient setting, and CPT code 64508, which meets the inpatient criterion but is performed over 50 percent of the time in a physician's office. Since all these nerve injection codes fail to meet at least one of the criteria for addition, we are not adding them to the ASC list.

Comment: One commenter proposed the addition of CPT code 64421 (injection of intercostal nerves).

Response: CPT code 64421 is performed 31 percent of the time in a physician's office and 22 percent of the time on an inpatient basis. This procedure thus meets our criteria and will be added to the list (see Addendum B).

Comment: Two commenters proposed the addition to the ASC list of CPT code 64612, and one commenter proposed CPT code 64613. The descriptions of these CPT codes follow:

CPT Code	Description
64612	Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles enervated by facial nerve (eg, for blepharospasm, hemifacial spasm).
64613	Destruction by neurolytic agent (chemodenervation of muscle endplate); cervical spinal muscles (eg, for spasmodic torticollis).

Response: CPT code 64612 is performed in the physician's office 84 percent of the time, and CPT code 64613

is performed in the physician's office 74 percent of the time. Thus, the codes fail to meet the criteria for our list.

Eye and Ocular Adnexa

Comment: One commenter proposed the addition of CPT code 65770 (keratoprosthesis).

Response: CPT code 65770 is performed 10 percent of the time in a physician's office and 62 percent of the time on an inpatient basis. This procedure thus meets our criteria and will be added to the list (see Addendum B).

Comment: Several commenters suggested adding CPT code 65772 (corneal relaxing incision for correction of surgically induced astigmatism), and one suggested adding code CPT code 65775 (corneal wedge resection for correction of surgically induced astigmatism).

Response: Neither procedure meets our inpatient criterion. CPT codes 65772 is performed 1 percent of the time on an inpatient basis, and CPT code 65775 is performed 3 percent of the time on an inpatient basis. Therefore, we are not adding them to the ASC list.

Comment: Commenters proposed the addition of the following CPT codes:

CPT Code	Description
65855	Trabeculoplasty by laser surgery, one or more sessions (defined treatment series).
66761	Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (one or more sessions).
67145	Chemodenervation of extraocular muscle.
67210	Destruction of localized lesion of retina (eg, maculopathy, choroidopathy, small tumors), one or more sessions; photocoagulation (laser or xenon arc).
67228	Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; photocoagulation (laser or xenon arc).

Commenters stated that these codes are already performed from 25 percent to 40 percent of the time in the OPD, and their failure to meet the 20 percent inpatient criterion should not preclude their addition to the ASC list.

Response: A review of our most recent billing data indicates that none of these procedures is performed 40 percent of the time in the OPD; rather, they are performed from 14 percent to 30 percent of the time in the OPD. However, each of these procedures is performed from 58 percent to 79 percent of the time in a physician's office. Since these procedures not only fail to meet the 20 percent inpatient criterion but also the 50 percent physician's office criterion, they will not be added to the ASC list.

Comment: One commenter proposed the following CPT codes for addition to the list:

CPT Code	Description
65125	Modification of ocular implant (eg, drilling receptacle for prosthesis appendage) (separate procedure).
65860	Severing adhesions of anterior segment, laser technique (separate procedure).
66172	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents).
66825	Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure).

Response: CPT codes 65125 and 66825 do not meet the inpatient criterion. CPT code 65125 is performed 5 percent of the time on an inpatient basis, and CPT code 66825 is performed 7 percent of the time on an inpatient basis. CPT code 65860 is performed in a physician's office 65 percent of the time. CPT code 66172 is a new code added in 1994 and is not cross-referred to a procedure currently covered in an ASC. We generally need a year of billing data before we can make a decision as to the appropriate setting for performance. Therefore, none of these codes will be added to the ASC list.

Comment: One commenter proposed the addition of CPT code 66820 (discission of secondary membraneous cataract, stab incision).

Response: CPT code 66820 is performed 5 percent of the time on an inpatient basis and 53 percent of the time in a physician's office and, thus, fails to meet our criteria and will not be added to the list.

Comment: Commenters proposed the addition of the following codes:

CPT Code	Description
67345	Chemodenervation of extraocular muscle.
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach).
68115	Excision of lesion, conjunctiva; over 1 cm.

Response: CPT code 67345 is a physician's office procedure, performed 85 percent of the time in that setting. CPT codes 67900 and 68115 fail to meet our inpatient criterion with only 3 percent each inpatient performance. Therefore, these codes will not be added to the ASC list.

Auditory System

Comment: Commenters proposed the addition of CPT code 69433 (tympanostomy).

Response: This procedure is performed 91 percent of the time in a physician's office. Therefore, it fails to meet the criteria for inclusion on the ASC list.

Other Procedures

Comment: One commenter proposed the use of hyperbaric medical treatment in an ASC with payment for an appropriate technical component. The commenter stated that the routine care of wounds in conjunction with the use of hyperbaric treatments is included under CPT code 99183, but this code does not include coverage of technical costs in an ASC.

Response: The Medicare list of surgical procedures covered in an ASC includes only surgical procedures listed in the surgical section of the CPT. Hyperbaric medical treatment is not surgery and is listed in the CPT under miscellaneous, special services. Thus, we cannot add it to the ASC list.

Proposed Deletions

Integumentary System

Comment: We proposed to delete nine skin lesion excision codes: CPT codes 11042, 11424, 11604, 13101, 13121, 13132, 13152, 14040, and 14041. All nine codes received comments opposing their deletion. Commenters stated that these procedures may sometimes involve complications and compromise safety in the physician's office.

Response: The physician's office site of performance for these procedures ranges from 53 percent to 71 percent. However, each of these CPT procedure codes involves a range of lesion sizes and anatomical sites. For example, CPT code 11424, representing a 3.1 to 4.0 cm. lesion, includes scalp, neck, hands, feet, and genitalia. While a 4 cm. foot or hand lesion may be excised in the physician's office, a 4 cm. lesion on the genitalia requires a higher surgical setting. Larger size lesions, especially if malignant, require the sterile environment of an operating room, extensive anesthesia, and the monitoring of patient cardiovascular parameters and vital signs. Our medical staff thus believe the commenters are correct that our site-of-service data for these codes are deceptive.

As we have stated earlier in this notice and in previous notices, we may occasionally make an exception to our general criteria, if, based on the advice of our medical staff, we believe that the site-of-service data are deceptive. We

are making an exception to the criteria and retaining all the referenced skin lesion codes, based on the recommendation of our medical staff and consultants.

Cardiovascular System

Comment: Commenters opposed the deletion of the following codes:

CPT Code	Description
36530	Insertion of implantable intravenous infusion pump.
36531	Revision of implantable intravenous infusion pump.
36532	Removal of implantable intravenous infusion pump.

Response: We stated in the proposed notice that the Office of Health Technology Assessment (OHTA), a component of the Public Health Service's Agency for Health Care Policy and Research, would be issuing an assessment on the safety and efficacy of infusion pumps for certain treatments and we would re-evaluate our policy on these pumps in light of that assessment. OHTA issued its assessment, and consequently we revised our manual instruction in section 60–14B of the Medicare Coverage Issues Manual. According to this revision, the former instruction limiting Medicare coverage of infusion pumps to intra-arterial pumps for certain medical conditions has been revised to include intravenous infusion pumps for a greater number of medical indications. As a result, we are not deleting CPT codes 36530, 36531, and 36532.

Comment: Several commenters were opposed to our deletion of CPT code 63750 (insertion, subarachnoid catheter with reservoir and/or pump for intermittent or continuous infusion of drug, including laminectomy) and CPT code 63780 (insertion or replacement, subarachnoid or epidural catheter, with reservoir and/or pump for drug infusion, without laminectomy).

Response: Our medical advisors state that these procedures can be performed safely, effectively, and appropriately in the ASC setting. We are therefore retaining these procedures on the list.

Urinary System

Comment: We received over 300 comments in opposition to the deletion of CPT code 52000 (cystourethroscopy (separate procedure)). Of these comments, 200 were also against deleting the following CPT codes:

CPT Code	Description
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female.
52285	Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incision of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone.

Most commenters opposed to the cystoscopy's deletion were urologists. The main themes mentioned by the commenters were the following: the differences in male and female cystoscopies, the differences in type of cystoscopies, diagnostic versus therapeutic cystoscopies, our deceptive data, and physician/patient access problems.

Response: Although the three cystoscopies proposed for deletion exceed our physician's office criterion, we are making an exception to this standard and retaining these codes on the list, based on the advice of our medical staff and consultants. Numerous commenters offered significant medical evidence for retention of cystoscopies on the ASC list, especially for male patients. Moreover, an exhaustive review of our data supports the commenters' belief that female cystoscopies skew the data in favor of the physician's office site of service and many CPT code 52000 cystoscopies, when performed, are upgraded to therapeutic cystoscopies and not reported under CPT code 52000.

Male Genital System

Comment: We received 136 comments in opposition to the deletion of CPT code 55700 (prostate biopsy). The following were the main themes mentioned in the comments: patient health, complications and infection, sterilization problems, and the use of the ultrasound machine.

Response: As with cystoscopies, information indicates many patients in need of a prostate biopsy have comorbidities or other complications that necessitate close monitoring. Complications of prostate biopsy can be serious. Infection and bleeding are not uncommon and, at times, warrant hospital admission.

Although prostate biopsy exceeds our physician's office criterion, we are making an exception to our standard and are retaining this procedure on the list. We base our determination on the number of comments received citing significant medical evidence, and the advice of our medical staff and consultants that prostate biopsy is an appropriate procedure for the ASC list.

Nervous System

Comment: Several commenters were opposed to our proposed deletion of the following codes:

CPT Code	Description
64442	Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, single level.
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic).

They believed these codes should not be deleted because they frequently require the standby of a crash cart, should a complication occur during injection. CPT code 64442 requires a fluoroscopy, which few physicians' offices own; CPT code 64510 may compromise the patient's airway with the inadvertent block of a laryngeal nerve with a local anesthetic; and both procedures cause patient cardiac arrhythmias in 25 percent of patients. Commenters believed our data are erroneous since the data exclude anesthesiologists from site-of-service data, and anesthesiologists are the primary physicians performing these procedures.

Response: In view of these stated medical concerns and because the inclusion of anesthesiologists in a new claims data run resulted in the two procedures falling below the 50 percent physician's office criterion, both procedures will be retained on the list.

Eye and Ocular Adnexa

Comment: We received comments in opposition to our proposed deletion of the following ophthalmologic procedures codes:

CPT Code	Description
66762	Iridoplasty by photocoagulation (one or more sessions) (eg, for improvement of vision, for widening of anterior chamber angle).
67101	Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid.
67105	Repair of retinal detachment, photocoagulation (laser or xenon arc, one or more sessions), with or without drainage of subretinal fluid.

CPT Code	Description
67208	Destruction of localized lesion of retina (eg, maculopathy, choroidopathy, small tumors), one or more sessions; cryotherapy, diathermy.
67921	Entropion repair; suture.

Commenters were concerned that these procedures could not be performed in a physician's office without the purchase of costly equipment and they would now have to be performed in the more expensive OPD setting.

Response: The billing data on site-of-service performance for four of these five procedures (excluding CPT code 67921) range from 53 percent to 63 percent physicians' office performance. When considering the combined ASC, OPD, and inpatient hospital performances, these four procedures do not meet the new 46 percent threshold criterion; rather their combined percentages range from 37 percent to 40 percent. In view of these combined percentages, we believe we are justified in adhering to our proposed intention to delete from the ASC list CPT codes 66762, 67101, 67105, and 67208.

The fifth code, CPT code 67921, has a 45 percent combined percentage performance in the three settings. Yet, our medical staff advise us that this procedure, which involves the inversion of the border of the eyelid against the eyeball, is medically appropriate for performance in the ASC. This code is also one of a series of ophthalmological codes involving blepharoplasties mentioned both in this notice and in the previous ASC final notice published in the **Federal Register** on December 31, 1991 (56 FR 67666) as making unnecessary our coverage of integumentary system blepharoplasties, which are sometimes cosmetic. In view of these factors, we are making an exception to our criteria and are retaining CPT code 67921.

Comment: Commenters believed that four of the ophthalmic procedures proposed for removal from the list are subject to the interim practice cost reductions. They are the following CPT codes:

CPT Code	Description
66762	Iridoplasty by photocoagulation (one or more sessions) (eg, for improvement of vision, for widening of anterior chamber angle).
67101	Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid.
67105	Repair of retinal detachment, photocoagulation (laser or xenon arc, one or more sessions), with or without drainage of subretinal fluid.
67208	Destruction of localized lesion of retina (eg, maculopathy, choroidopathy, small tumors), one ore more sessions; cryotherapy, diathermy.

The commenters stated that we should not remove any procedures subject to the interim practice cost reductions from the ASC list until the fee schedule for physicians' services accurately reflects practice costs.

Response: The commenters are correct that four of the five ophthalmic procedures (CPT codes 66762, 67101, 67105, and 67208) proposed for deletion from the ASC list are subject to the practice expense reduction. (CPT code 67921 (repair of entropion) is not subject to the practice expense reduction.)

OBRA '93 provides for an adjustment to practice expense relative value units (RVUs) for services for which practice expense RVUs exceed 128 percent of the work RVUs and that are performed less than 75 percent of the time in a physician's office setting. The 1994 practice expense RVUs are reduced by 25 percent of the amount by which the practice expense RVUs exceed the 1994 work RVUs. In 1995 and 1996, the excess, as determined for 1994, will be reduced an additional 25 percent each year. Practice expense RVUs will not be reduced to an amount less than 128 percent of the 1994 work RVUs for a service. Services performed more than 75 percent of the time in a physician's office setting are not subject to the reduction.

Services that are primarily performed in a physician's office setting are subject to a payment limit, called the site-of-service limitation, if they are performed in an inpatient hospital or OPD setting. For these procedures, the practice expense RVUs are reduced by 50 percent. The limitation on the practice expense RVUs reflects lower practice costs incurred in the OPD. Procedures on the approved ASC list are automatically excluded from this site-of-service limitation.

We disagree that it is inappropriate to apply the site-of-service limitation to procedures subject to the practice expense reduction. These are two separate limitations established for different purposes. The practice expense reduction is designed to reduce the basic practice expense that has been determined by the Congress to be excessive; whereas the site-of-service limitation applies to procedures primarily performed in an office setting, when the procedures are performed in an inpatient hospital or OPD setting.

Procedures Intended for Deletion

In Addendum E of our December 1993 proposed notice, we published a list of procedures that we intended for deletion that were either recent additions to the list or had low-volume ASC performance or both. The following procedure codes in that addendum received comments.

Comment: Two commenters were opposed to the deletion of CPT code 64420, and one commenter opposed the deletion of CPT codes 65270 and 65272. The descriptions of these CPT codes follow:

CPT Code	Description
64420	Injection, anesthetic agent; intercostal nerve single.
65270	Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure.
65272	Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization.

Response: We are retaining these procedures on our list, but we restate our intention to delete them in our next biennial update should they continue to fail to meet our criteria.

Assignment of Payment Groups

Comment: Three commenters disagreed with the proposed payment group assignment of CPT code 66180 (aqueous shunt to extraocular reservoir, (eg, Molteno, Schocket, Denver-Krupin)) to payment group 4. Two commenters, both physicians, recommended that the procedure be placed in payment group 7 because of the time required to perform the procedure and other factors related to postoperative recovery. One commenter, a professional society, compared the procedure in terms of complexity to a scleral buckling procedure for retinal detachment (CPT code 67107) or the placement of a radioactive implant for an ophthalmic malignancy (CPT 67218), both of which are assigned to payment group 5.

Response: After consultation with our medical advisor, we concur with the professional society that CPT code 66180 more closely resembles procedures currently in payment group 5 in terms of time and resource consumption than it does those in payment group 4 or in payment group 7. We have therefore assigned this procedure to payment group 5. Payment for the aqueous shunt itself (HCFA

Common Procedure Coding System (HCPCS) code L8612) is not a part of the facility fee, but rather is made separately under Medicare Part B.

Comment: A dozen commenters disagreed with the assignment of CPT code 58990 (hysteroscopy, diagnostic) to payment group 1, recommending that it be placed in payment group 3.

Response: CPT code 58990 was added as a payment group 1 procedure to the list of Medicare-covered ASC procedures, effective for services furnished beginning on January 30, 1992. CPT code 58990 was replaced by CPT code 56350 (hysteroscopy, diagnostic (separate procedure)) in the 1993 CPT, and CPT code 58990 was deleted from both the CPT and the ASC list. Because this change constituted essentially an editorial rather than a substantive revision, we retained CPT code 56350 in payment group 1, the same payment group to which its predecessor, CPT code 58990, had been assigned. CPT code 56350 is on the list of procedures for which we are collecting resource cost data in Part II of the Medicare ASC survey, and its payment group assignment, along with that of all other procedures on the list of Medicare-covered ASC procedures, will be reevaluated within the context of the survey data. In the interim, CPT code 56350 will remain in payment group 1.

Additional Information

We received several dozen comments on payment issues that were not raised in our December 1993 proposed notice. Primarily, commenters recommended placing CPT codes that are currently on the ASC list in a higher payment group. A few commenters expressed disappointment over the lack of a payment rate update for inflation as a result of the 2-year freeze enacted by the Congress in OBRA '93.

As indicated in our December 1993 proposed notice, we are deferring changes of payment group assignments for individual procedures on the current ASC list pending completion of Part II of the Medicare ASC payment rate survey (Form HCFA 452B). On March 15, 1994, we mailed the Medicare ASC survey, Part II, to 320 facilities that constitute a randomly selected, representative sample of Medicare-participating ASCs. The survey collects data on facility overhead and procedure-specific costs. The payment group assignment and payment group amounts for all CPT codes on the list of Medicare-covered ASC procedures will be reviewed collectively, within the context of the survey data. Therefore, while we are not making any changes in existing payment group assignments in this notice, we will publish in the **Federal Register** in accordance with notice and comment procedures any changes that we propose to make on the basis of updated cost data collected in the ASC survey.

IV. Provisions of the Final Notice

We are adopting the following new quantitative criteria, suggested in our December 1993 proposed notice, for deleting a procedure from ASC coverage: The combined inpatient, OPD, and ASC site-of-service percentage is less than 46 percent of the total volume; and either—

- The procedure is performed 50 percent of the time or more in a physician's office; or
- The procedure is performed 10 percent of the time or less in an inpatient hospital setting.

This change allows the site of service for procedures in the physician's office to grow from below 50 percent (when it is added) to as high as 54 percent, as long as the proportion of time the procedure is performed in the operating room remains at 46 percent. Similarly, the criteria allow procedures to move from an inpatient hospital site of service to an OPD site of service without being deleted from the ASC list.

We are deleting 4 of the 25 procedure codes we had proposed for deletion from the ASC list in our December 1993 proposed notice. For the reasons discussed in the analysis of the public comments in section III. of this notice, we are retaining the remaining 21 codes on the ASC list. Addendum A lists the 4 CPT codes that we are deleting (with the body system and description of each procedure, according to appropriate CPT terminology). Addendum A also lists a fifth deletion, CPT code 36522 (photopheresis, extracorporeal), which was not suggested in our December 1993 proposed notice. We are deleting this code based on information from a provider that this procedure cannot be safely performed in an ASC. Our review of the billing data indicates that, although this procedure has been on the ASC list, it is performed 0 percent of the time in an ASC. It is performed 73 percent of the time on an inpatient basis and 23 percent of the time in the OPD. We are requesting public comment on the appropriateness of this deletion.

We are adding a total of 30 new procedure codes to the ASC list. These codes are listed in Addendum B with the body system and description of each procedure and the corresponding payment group. We are adding the 20 procedure codes that we had proposed for addition to the ASC list in our December 1993 proposed notice. For the reasons discussed in the analysis of the public comments in section III. of this notice, we are also adding 10 other procedure codes: CPT codes 29804, 43259, 51040, 52450, 56309, 56316, 56317, 56351, 56356, and 64421. We are requesting public comment on the appropriateness of the addition of these 10 new CPT codes and the assignment of payment groups for them since these codes were not suggested in our December 1993 proposed notice.

Further, the CPT is updated annually and some deletions and additions affect the ASC list. Parts 1 and 3 of Addendum C list CPT codes (with the body system and description of each procedure) that were deleted by changes to the Medicare Carriers Manual as a result of the update of the 1992 and 1993 editions of the CPT, respectively. We had proposed these deletions in our December 1993 proposed notice and received no comments on them. This notice makes these deletions final. Parts 2 and 4 of Addendum C list CPT codes (with the body system and description of each procedure and corresponding payment group) that were added by changes to the Medicare Carriers Manual as a result of the update of the 1992 and 1993 editions of the CPT. We had proposed these additions in our December 1993 proposed notice and received no comments on them. This notice makes these additions final. Part 5 of Addendum C lists CPT codes (with the body system and description of each procedure) that were deleted by changes to the Medicare Carriers Manual as a result of the update of the 1994 edition of the CPT. Because these codes were not suggested for deletion in our December 1993 proposed notice, we are now requesting public comment on the appropriateness of these deletions. This list of deletions differs from the Medicare Carriers Manual instruction that was effective April 11, 1994, in that we are retaining four of the nasal and sinus endoscopy codes: CPT codes 31254 through 31256 and 31267. We are retaining these codes since we anticipate that they will be reinstated by the CPT Editorial Panel effective January 1995. Part 6 of Addendum C lists CPT codes (with the body system and description of each procedure and corresponding payment group) that were added by changes to the Medicare Carriers Manual as a result of the update of the 1994 edition of the CPT. Because these codes were not suggested for addition in our December 1993 proposed notice, we are now requesting public comment on the appropriateness

of, and assignment of payment groups for, the additions.

V. 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.).

VI. Regulatory Impact Statement

A. Introduction

This final notice permits facility fees to be paid when the 30 surgical procedure codes being added by this notice are performed in an ASC. We are also deleting 5 codes from the ASC list. We believe the net effect of the addition and deletion of these codes will be negligible because of the low number of changes we are making at this time and because of the relatively low cost and volume of these codes.

Payments to ASCs are generally lower than payments to hospitals for surgery performed in a hospital, whether on an inpatient or OPD basis. Although we do not anticipate that many services will shift from the hospital inpatient setting to ASCs, we anticipate some program savings because payments to ASCs for a given surgical procedure are generally lower than payments to hospitals for the same procedure. Additional savings will be realized as a result of lower payments to a hospital when newly listed procedures continue to be performed on an OPD basis, because the OPD rate (less deductible and coinsurance) would be the lower of (1) the hospital's reasonable costs or charges, or (2) a blend of the hospital's reasonable costs or customary charges and the amount that would be paid to a free-standing ASC in the same area for the same procedure. The blend is comprised of 42 percent hospital cost and 58 percent ASC payment rate. We believe payments based on the ASC blended rate are approximately 10 percent lower than payments based solely on reasonable cost. A factor that could offset some savings would be a shift of services from the physician's office to the ASC setting as a result of the expansion of the list of covered ASC services. Since a facility fee is not paid when surgery is performed in a physician's office, this shifting will result in slightly increased program costs.

The deletions to the ASC list could also result in some changes in program costs and savings depending upon whether the deleted services are shifted to the lower cost physician's office site or to the higher cost OPD setting. We do not anticipate mass shifting of the site of service associated with the procedure codes we are adding or deleting.

We believe this notice will result in no economic impact.

B. 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 notice will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, all physicians, ASCs, and hospitals are considered to be small entities.

In addition, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a notice may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the 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.

We will delete a procedure from the ASC list only if the combined hospital inpatient, OPD, and ASC site-of-service percentage is less than 46 percent of the total volume; and either the procedure is performed 50 percent of the time or more in a physician's office, or the procedure is performed 10 percent of the time or less in an inpatient hospital setting. Because procedures will not be added or deleted as a result of slight shifts of the site of service, we believe we are adding stability to the list that should assist all small entities to plan for the future.

Therefore, for the reasons cited above, we are not preparing analyses for either the RFA or section 1102(b) of the Act since we have determined, and the Secretary certifies, that this notice will not result in a significant economic impact on a substantial number of small entities and will not have a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this notice was not reviewed by the Office of Management and Budget.

(Section 1833(i)(1) of the Social Security Act (42 U.S.C. 1395l(i)(1))

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

Dated: October 28, 1994.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: December 10, 1994.

Donna E. Shalala,

Secretary.

Addendum A

Deletions From the List of Covered Procedures for Ambulatory Surgical Centers

The following addendum is the final list of deletions from the ASC list. These deletions are effective April 26, 1995. In the first column is the CPT code for the procedure; and in the second column, the body system and description of the procedure. In this addendum, ''combined'' percentage refers to the total of inpatient hospital, hospital outpatient department, and ASC site-of-service percentages.

We are requesting public comments only on CPT code 36522 in Addendum A because we had not proposed this code for deletion in our December 1993 proposed notice.

CPT Code	Body system and description
	CARDIOVASCULAR SYSTEM
36522	Photopheresis, extracorporeal (73 percent inpatient, 2 percent office, 96 percent combined)
	EYE AND OCULAR ADNEXA
66762	Iridoplasty by photocoagulation (one or more sessions) (eg, for improvement of vision, for widening of anterior chamber angle) (2 percent inpatient, 59 percent office, 37 percent combined)
67101	Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid (8 percent inpatient, 62 percent office, 37 percent combined)
67105	Repair of retinal detachment, one or more sessions; photocoagulation (laser or xenon arc, one or more sessions), with or without drainage of subretinal fluid (6 percent inpatient, 63 percent office, 36 percent combined)
67208	Destruction of localized lesion of retina (eg, maculopathy, choroidopathy, small tumors), one or more sessions; cryotherapy, diathermy (5 percent inpatient, 57 percent office, 40 percent combined)

Addendum B

Additions to the List of Covered Procedures for Ambulatory Surgical Centers

The following addendum is the final list of additions to the ASC list and the

corresponding payment groups. These additions are effective February 27, 1995. In the first column is the CPT code for the procedure; in the second column, the payment group for the procedure; and in the third column, the body system and description of the procedure.

We are requesting public comments on the appropriateness of the addition of, and assignment of payment groups for, only the following CPT codes in Addendum B because we had not suggested them for addition in our December 1993 proposed notice: CPT codes 29804, 43259, 51040, 52450, 56309, 56316, 56317, 56351, 56356, and 64421.

CPT Code	Payment group	Body system and description
		MUSCULOSKELETAL SYSTEM
20694	1	Removal, under anesthesia, of external fixation system
20910	3	Cartilage graft; costochondral
26416	3	Removal of tube or rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger
26587	5	Reconstruction of supernumerary digit, soft tissue and bone
28307	4	Osteotomy, metatarsal, base or shaft, single, with or without lengthening, for shortening or angular correction; first metatarsal with autograft
28340	4	Reconstruction, toe, macrodactyly; soft tissue resection
28341	4	Reconstruction, toe, macrodactyly; requiring bone resection
28344	4	Reconstruction, toe(s); polydactyly
28345	4	Reconstruction, toe(s); syndactyly, with or without skin graft(s), each web
28456	2	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus); with manipulation, each
29804	3	Arthroscopy, temporomandibular joint, surgical
		RESPIRATORY SYSTEM
31084	4	Sinusotomy frontal; obliterative, with osteoplastic flap, brow incision
		DIGESTIVE SYSTEM
43259	3	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination
49250	4	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)
		URINARY SYSTEM
51040	4	Cystostomy, cystostomy with drainage
52450	3	Transurethral incision of prostate
		MALE GENITAL SYSTEM
54015	4	Incision and drainage of penis, deep
54205	4	Injection procedure for Peyronie disease; with surgical exposure of plaque
		LAPAROSCOPY/PERITONEOSCOPY/HYSTEROSCOPY
56309	5	Laparoscopy, surgical; with removal of leiomyomata, subserosal (single or multiple)
56316	4	Laparoscopy, surgical; repair of initial inguinal hernia
56317	7	Laparoscopy, surgical; repair of recurrent inguinal hernia
56351	3	Hysteroscopy, surgical, with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
56356	4	Hysteroscopy, surgical; with endometrial ablation (any method)
		FEMALE GENITAL SYSTEM
56441	1	Lysis of labial adhesions
		NERVOUS SYSTEM
62275	1	Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; epidural, cervical or thoracic, single
64421	1	Injection, anesthetic agent; intercostal nerves, multiple, regional block
		EYE AND OCULAR ADNEXA
65770	7	Keratoprosthesis
66180	5	Aqueous shunt to extraocular reservoir, (eg, Molteno, Schocket, Denver-Krupin)
66185	2	Revision of aqueous shunt to extraocular reservoir
67340	4	Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s)

Addendum C

1. Deletions From the List of Covered Procedures for Ambulatory Surgical Centers, Deleted From the 1992 CPT

The CPT is updated annually, and some additions and deletions affect the ASC list. The following part 1 of this addendum is the list of procedures that were deleted from the ASC list because they were deleted from the 1992 CPT. These deletions were effective March 31, 1992. In the first column is the CPT code for the procedure; and in the second column, the body system and description of the procedure.

CPT code	Body system and description
	INTEGUMENTARY SYSTEM
15410	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; 100 sq cm or less
15412	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis, between 101 and 160 sq cm
15414	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; between 161 and 230 sq cm
15416	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; over 230 sq cm
15500	Formation of tube pedicle without transfer or major "delay" of large flap without transfer; on trunk
15505	Formation of tube pedicle without transfer or major "delay" of large flap without transfer; on scalp, arms, or legs
15510	Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet
15515	Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on eyelids, nose, ears, or lips
15540	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to trunk
15545	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to scalp, arms, or legs
15550	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to forehead, cheeks, chin, mouth, neck, axillae, genitalia, or hands, feet
15555	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to eyelids, nose, ears, or lips
15700	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; trunk

CPT code	Body system and description
15710	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; scalp, arms, or legs
15720	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15730	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; eyelids, nose, ears, or lips
15954	Excision, trochanteric pressure ulcer, with bipedicle flap closure
15955	Excision, trochanteric pressure ulcer, with bipedicle flap closure; with ostectomy
15960	Excision, heel pressure ulcer, with primary suture
15961	Excision, heel pressure ulcer, with primary suture; with ostectomy
15964	Excision, heel pressure ulcer, with local skin flap closure
15965	Excision, heel pressure ulcer, with local skin flap closure; with ostectomy
15966	Excision, heel pressure ulcer, with other flap closure
15967	Excision, heel pressure ulcer, with other flap closure; with ostectomy
15970	Excision, leg pressure ulcer, with primary suture
15971	Excision, leg pressure ulcer, with primary suture; with ostectomy
15972	Excision, leg pressure ulcer, with local skin flap(s)
15973	Excision, leg pressure ulcer, with local skin flap(s); with ostectomy
15974	Excision, leg pressure ulcer, with muscle or myocutaneous flap closure
15975	Excision, leg pressure ulcer, with muscle or myocutaneous flap closure; with ostectomy
15980	Excision, knee pressure ulcer, with local skin flap closure
15981	Excision, knee pressure ulcer, with local skin flap closure; with ostectomy
15982	Excision, knee pressure ulcer, with other flap closure
15983	Excision, knee pressure ulcer, with other flap closure; with ostectomy
19360	Breast Reconstruction with muscle or myocutaneous flap
	RESPIRATORY SYSTEM
30820	Cryosurgery of turbinates, unilateral or bilateral
	CARDIOVASCULAR SYSTEM
36495	Insertion of implantable intravenous infusion pump or venous access port
36496	Revision of implantable intravenous infusion pump or venous access port
36497	Removal of implantable intravenous infusion pump or venous access port
	EYE AND OCULAR ADNEXA
66702	Ciliary body destruction, any method (eg, diathermy, cryotherapy, laser, dialysis)
67907	Repair of blepharoptosis; superior rectus tendon transplant

2. Additions to the List of Covered Procedures for Ambulatory Surgical Centers, Added to the 1992 CPT (Added to the Medicare Carriers Manual January 30, 1992)

The CPT is updated annually, and some additions and deletions affect the ASC list. The following part 2 of this addendum is the list of procedures that were added to the ASC list because of additions to the 1992 CPT. These procedures were added to the ASC list by the Medicare Carriers Manual and were effective January 30, 1992. In the first column is the CPT code for the procedure; in the second column, the payment group for the procedure; and in the third column, the body system and description of the procedure.

CPT code	Payment group	Body system and description
		INTEGUMENTARY SYSTEM
15570	3	Formation of direct or tubed pedicle, with or without transfer; trunk
15572	3	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
15574	3	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet
15576	3	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips or intraoral
19357	5	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
		RESPIRATORY SYSTEM
30801	1	Cauterization and/or ablation, mucosa of turbinates, unilateral or bilateral, any method (separate procedure); superficial
30802	1	Cauterization and/or ablation, mucosa of turbinates, unilateral or bilateral, any method (separate procedure); intramural
		CARDIOVASCULAR SYSTEM
36533	3	Insertion of implantable venous access port, with or without subcutaneous reservoir
36534	2	Revision of implantable venous access port and/or subcutaneous reservoir
36535	1	Removal of implantable venous access port and/or subcutaneous reservoir
		EYE AND OCULAR ADNEXA
66700	2	Ciliary body destruction; diathermy
66710	2	Ciliary body destruction; cyclophotocoagulation
66720	2	Ciliary body destruction; cryotherapy
66740	2	Ciliary body destruction; cyclodialysis
66986	6	Exchange of intraocular lens

3. Deletions from the List of Covered Procedures for Ambulatory Surgical Centers, Deleted From the 1993 CPT

The CPT is updated annually, and some additions and deletions affect the ASC list. The following part 3 of this addendum is the list of procedures that were deleted from the ASC list because they were deleted from the 1993 CPT. These deletions were effective July 7, 1993. In the first column is the CPT code for the procedure; and in the second column, the body system and description of the procedure.

CPT Code	Body system and description
	INTEGUMENTARY SYSTEM
10141	Incision and drainage of hematoma; complicated
	MUSCULOSKELETAL SYSTEM
21455	Closed manipulative treatment by interdental fixation of closed or open mandibular fracture
23510	Treatment of open clavicular fracture, with uncomplicated soft tissue closure
23580	Treatment of open scapular fracture with uncomplicated soft tissue closure
23610	Treatment of open humeral (surgical or anatomical neck) fracture, with uncomplicated soft tissue closure
23658	Treatment of open shoulder dislocation, with uncomplicated soft tissue closure
24506	Treatment of closed humeral shaft fracture; percutaneous insertion of pin or rod
24510	Treatment of open humeral shaft fracture, with uncomplicated soft tissue closure

CPT Code	Body system and description
24531	Treatment of closed humeral supracondylar or transcondylar fracture, without manipulation; with traction (pin or skin)
24536	Treatment of closed humeral supracondylar or transcondylar fracture, with manipulation; with traction (pin or skin)
24540	Treatment of open humeral supracondylar or transcondylar fracture, with uncomplicated soft tissue closure
24542	Treatment of open humeral supracondylar or transcondylar fracture, with uncomplicated soft tissue closure, with traction (pin or skin)
24570	Treatment of open humeral epicondylar fracture, medial or lateral, with uncomplicated soft tissue closure
24578	Treatment of open humeral condylar fracture, medial or lateral, with uncomplicated soft tissue closure
24580	Treatment of closed comminuted elbow fracture (fracture distal humerus and/or proximal ulna and/or proximal radius), treatment with traction (pin or skin), without manipulation
24581	Treatment of closed comminuted elbow fracture (fracture distal humerus and/or proximal ulna and/or proximal radius), treatment with traction (pin or skin); with manipulation
24583	Treatment of open comminuted elbow fracture (fracture distal humerus and/or proximal ulna and/or proximal radius), with uncomplicated soft tissue closure
24585	Open treatment of closed or open comminuted elbow fracture (fracture distal humerus and/or proximal radius), with or without internal or external skeletal fixation
24588	Open treatment of closed or open comminuted elbow fracture (fracture distal humerus and/or proximal radius), with implants and fascia lata ligament reconstruction
24610	Treatment of open elbow dislocation, with uncomplicated soft tissue closure
24625	Treatment of open Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with uncomplicated soft tissue closure
24660	Treatment of open radial head or neck fracture, with uncomplicated soft tissue closure
24680	Treatment of open ulnar fracture, proximal end (olecranon process), with uncomplicated soft tissue closure
25510	Treatment of open radial shaft fracture, with uncomplicated soft tissue closure
25540	Treatment of open ulnar shaft fracture, with uncomplicated soft tissue closure
25570	Treatment of open radial and ulnar shaft fractures, with uncomplicated soft tissue closure
25610	Treatment of closed, complex, distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal fixation or percutaneous pinning
25615	Treatment of open distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with uncomplicated soft tissue closure
25626	Treatment of open carpal scaphoid (navicular) fracture, with uncomplicated soft tissue closure
25640	Treatment of closed carpal bone fracture (excluding carpal scaphoid (navicular), with uncomplicated soft tissue closure, each bone
25665	Treatment of open radiocarpal or intercarpal dislocation, one or more bones, with uncomplicated soft tissue closure
26610	Treatment of open metacarpal fracture, single, with uncomplicated soft tissue closure, each bone
26655	Treatment of open carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external skeletal fixation
26660	Treatment of open carpometacarpal fracture dislocation, thumb (Bennett fracture), with skeletal fixation
26680	Treatment of open carpometacarpal dislocation, other than Bennett fracture, single, with uncomplicated soft tissue closure
26710	Treatment of open metacarpophalangeal dislocation, single, with uncomplicated soft tissue closure
26730	Treatment of open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with uncomplicated soft tissue closure, each
26744	Treatment of open articular fracture, involving metacarpophalangeal or proximal interphalangeal joint, with uncomplicated soft tissue closure, each
26780	Treatment of open interphalangeal joint dislocation, single, with uncomplicated soft tissue closure
27190	Treatment of closed sacral fracture
27192	Open treatment of closed or open sacral fracture
27195	Treatment of sacroiliac and/or symphysis pubis dislocation, without manipulation
27196	Treatment of sacroiliac and/or symphysis pubis dislocation, with anesthesia and with manipulation
27201	Treatment of open coccygeal fracture
27210	Treatment of closed iliac, pubic or ischial fracture
27504	Treatment of open femoral shaft fracture (including supracondylar), with uncomplicated soft tissue closure
27512	Treatment of open femoral fracture, distal end, medial or lateral condyle, with uncomplicated soft tissue closure
27522	Treatment of open patellar fracture, with uncomplicated soft tissue closure
27534	Treatment of open tibial fracture, proximal (plateau), with uncomplicated soft tissue closure
27564	Treatment of open patellar dislocation, with uncomplicated soft tissue closure
27754	Treatment of open tibial shaft fracture, with uncomplicated soft tissue closure
27764	Treatment of open distal tibial fracture (medial malleolus), with uncomplicated soft tissue closure
27782	Treatment of open proximal fibula or shaft fracture, with uncomplicated soft tissue closure
27790	Treatment of open distal fibular fracture (lateral malleolus), with uncomplicated soft tissue closure
27800	Treatment of closed tibia and fibula fractures, shafts; without manipulation
27802	Treatment of closed tibia and fibula fractures, shafts; with manipulation
27804	Treatment of open tibia and fibula fractures, shafts, with uncomplicated soft tissue closure (eg "pins above and below")
27812	Treatment of open bimalleolar ankle fracture, with uncomplicated soft tissue closure
27820	Treatment of open trimalleolar ankle fracture, with uncomplicated soft tissue closure
27844	Treatment of open ankle dislocation, with uncomplicated soft tissue closure
28410	Treatment of open calcaneal fracture, with uncomplicated soft tissue closure
28440	Treatment of open talus fracture, with uncomplicated soft tissue closure
28460	Treatment of open tarsal bone fracture (except talus and calcaneous), with uncomplicated soft tissue closure, each
28480	Treatment of open metatarsal fracture, with uncomplicated soft tissue closure, each
28500	Treatment of open fracture great toe, phalanx or phalanges, with uncomplicated soft tissue closure
28520	Treatment of open fracture, phalanx or phalanges, other than great toe, with uncomplicated soft tissue closure, each
28640	Treatment of open metatarsophalangeal joint dislocation, with uncomplicated soft tissue closure
28670	Treatment of open interphalangeal joint dislocation, with uncomplicated soft tissue closure

CPT Code	Body system and description
	RESPIRATORY SYSTEM
31719	Transtracheal (percutaneous) introduction of indwelling tube for therapy (eg, tickle tube, catheter for oxygen administration)
	FEMALE GENITAL SYSTEM
56000	Incision and drainage of perineal abscess (nonobstetrical)
56100	Biopsy of perineum (separate procedure)
56200	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57451	Culdoscopy, diagnostic; with biopsy and/or lysis of adhesions or tubal sterilization
58980	Laparoscopy, diagnostic (separate procedure)
58984	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
58985	Laparoscopy, surgical; with lysis of adhesions
58986	Laparoscopy, surgical; with biopsy (single or multiple)
58987	Laparoscopy, surgical; with aspiration (single or multiple)
58988	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58990	Hysteroscopy; diagnostic
58992	Hysteroscopy; with lysis of intrauterine adhesions or resection of intrauterine septum (any method)
58994	Hysteroscopy; with removal of submucous leiomyomata (any method)

4. Additions to the List of Covered Procedures for Ambulatory Surgical Centers, Added to the 1993 CPT (Added to the Medicare Carriers Manual January 1, 1993)

The CPT is updated annually, and some additions and deletions affect the ASC list. The following part 4 of this addendum is the list of procedures that were added to the ASC list because of additions to the 1993 CPT. These procedures were added to the ASC list by the Medicare Carriers Manual and were effective January 1, 1993. In the first column is the CPT code for the procedure; in the second column, the payment group for the procedure; and in the third column, the body system and description of the procedure.

CPT Code	Payment Group	Body system and description
		MUSCOLOSKELETAL SYSTEM
23616	4	Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(-ies); with proximal humeral prosthetic replacement
24516	4	Open treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws
24546	5	Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; with intercondylar extension
25520	1	Closed treatment of radial shaft fracture, with dislocation of distal radioulnar joint (Galeazzi fracture/dislocation)
25525	4	Open treatment of radial shaft fracture, with internal and/or external fixation and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with or without percutaneous skeletal fixation
25526	5	Open treatment of radial shaft fracture, with internal and/or external fixation and open treatment, with or without internal or external fixation of distal radioulnar (Galeazzi fracture/ dislocation), includes repair of triangular cartilage
25574	3	Open treatment of radial and ulnar shaft fractures, with internal or external fixation; of radius or ulna
27193	1	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation
27194	2	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia
27501	2	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation
27503	3	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension; with manipulation, with or without skin or skeletal traction
27507	4	Open treatment of femoral shaft fracture with plate/ screws, with or without cerclage
27509	3	Percutaneous skeletal fixation of supracondylar or transcondylar femoral fracture, with or without intercondylar extension
27511	4	Open treatment of femoral supracondylar fracture without intercondylar extension, with or without internal or external fixation
27513	5	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, with or without internal or external fixation
27535	3	Open treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation
27759	4	Open treatment of tibial shaft fracture (with or without fibular fracture) by intermedullary implant, with or without interlocking screws and/or cerclage
27824	1	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation
27825	2	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation
27826	3	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of fibula only
27827	3	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only

CPT Code	Payment Group	Body system and description
27828	4	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of both tibia and fibula
27829	2	Open treatment of distal tibiofibular joint (syndesmosis) disruption, with or without internal or external fixation
28576	3	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation
28636	3	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation
28666	3	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation
29850	4	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)
29851	4	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)
29855	4	Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation (includes arthroscopy)
29856	4	Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal or external fixation (includes arthroscopy)
		RESPIRATORY SYSTEM
31730	1	Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy
		FEMALE GENITAL SYSTEM
56300	3	Laparoscopy, diagnostic (separate procedure)
56303	5	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
56304	5	Laparoscopy, surgical; with lysis of adhesions
56305	4	Laparoscopy, surgical; with biopsy (single or multiple)
56306	4	Laparoscopy, surgical; with aspiration (single or multiple)
56307	5	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
56350	1	Hysteroscopy, diagnostic (separate procedure)
56352	2	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)
56354	3	Hysteroscopy, surgical; with removal of leiomyomata
56405	2	Incision and drainage of vulva or perineal abscess
56605	1	Biopsy of vulva or perineum (separate procedure); one lesion
56810	5	Perineoplasty, repair of perineum, non-obstetrical (separate procedure)

5. Deletions From the List of Covered Procedures for Ambulatory Surgical Centers, Deleted from the 1994 CPT

The CPT is updated annually, and some additions and deletions affect the ASC list. The following part 5 of this addendum is the list of procedures that were deleted from the ASC list because they were deleted from the 1994 CPT. These deletions were effective April 11, 1994. This list of deletions differs from the Medicare Carriers Manual instruction that was effective April 11, 1994, in that we have since decided to retain four of the nasal and sinus endoscopy codes: CPT codes 31254 through 31256 and 31267. We are retaining these codes since we anticipate that they will be reinstated by the CPT Editorial Panel effective January 1995.

In the first column is the CPT code for the procedure; and in the second column, the body system and description of the procedure.

We are requesting public comments on the appropriateness of the deletion of the CPT codes in Addendum C, part 5, because we had not suggested them for deletion in our December 1993 proposed notice.

CPT Code	Body system and description
	RESPIRATORY SYSTEM
31252	Nasal endoscopy, surgical; with nasal polypectomy
31258	Nasal endoscopy, surgical; with removal of foreign body(s)
31260	Maxillary sinus endoscopy, diagnostic, with or without biopsy (separate procedure)
31263	Maxillary sinus endoscopy, surgical; with removal of foreign body(s)
31265	Maxillary sinus endoscopy, surgical; with removal of cyst
31268	Maxillary sinus endoscopy, surgical; with removal of fungus ball
31270	Sphenoid endoscopy, diagnostic, with or without biopsy (separate procedure)
31275	Sphenoid endoscopy, surgical
31277	Sphenoid endoscopy, surgical; with removal of mucous membrane
	CARDIOVASCULAR SYSTEM
36820	Insertion of cannula for hemodialysis, other purpose; arteriovenous, internal (Climino type)
	DIGESTIVE SYSTEM
43451	Dilation of esophagus, by unguided sound or bougie, single or multiple passes; subsequent session
43455	Dilation of esophagus, by balloon or dilator; under fluoroscopic guidance
45310	Proctosigmoidoscopy; with removal of polyp or papilloma
45336	Sigmoidoscopy, flexible fiberoptic; with ablation of tumor or mucosal lesion (eg, electrocoagulation, laser photocoagulation, hot biopsy/fluguration)
46000	Fistulotomy, subcutaneous
49300	Peritoneoscopy; without biopsy
49301	Peritoneoscopy; with biopsy
49302	Peritoneoscopy with guided transhepatic cholangiography; without biopsy
49303	Peritoneoscopy with guided transhepatic cholangiography; with biopsy
49401	Pneumoperitoneum (separate procedure); subsequent
49510	Repair inguinal hernia, age 5 or over; with orchiectomy, with or without implantation of prosthesis
49515	Repair inguinal hernia, age 5 or over; with orchiectomy, with excision of hydrocele or spermatocele
49552	Repair femoral hernia, Henry approach
49575	Repair epigastric hernia, properitoneal fat (separate procedure); complex
49581	Repair umbilical hernia; age 5 or over

6. Additions to the List of Covered Procedures for Ambulatory Surgical Centers, Added to the 1994 CPT (Added to the Medicare Carriers Manual January 1, 1994)

The CPT is updated annually, and some additions and deletions affect the ASC list. The following part 6 of this addendum is the list of procedures that were added to the ASC list because of additions to the 1994 CPT. These procedures were added to the ASC list by the Medicare Carriers Manual and were effective January 1, 1994. In the

first column is the CPT code for the procedure; in the second column, the payment group for the procedure; and in the third column, the body system and description of the procedure.

We are requesting public comments on the appropriateness of the addition of, and assignment of payment groups for, the CPT codes in Addendum C, part 6, because we had not suggested them for addition in our December 1993 proposed notice.

CPT code	Payment group	Body system and description
		INTEGUMENTARY SYSTEM
19125	3	Excision of breast lesion identified by pre-operative placement of radiological marker; single lesion
19126	3	Excision of breast lesion identified by pre-operative placement of radiological marker; each additional lesion separately identified by a radiological marker
		MUSCULOSKELETAL SYSTEM
24566	2	Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation
24582	2	Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation
		RESPIRATORY SYSTEM
31233	2	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)
31235	1	Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of osteum)
31237	2	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)
31238	1	Nasal/sinus endoscopy, surgical; with control of epistaxis
31239	4	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy
31240	2	Nasal/sinus endoscopy, surgical; with concha bullosa resection
31245	3	Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s)
31246	3	Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s); with antrostomy
31247	3	Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s); with antrostomy and removal of antral mucosal disease
31248	3	Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s); with frontal sinus exploration
31249	3	Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s); with frontal sinus exploration and antrostomy
31251	3	Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s); with frontal sinus exploration, antrostomy, and removal of antral mucosal disease
31261	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s)
31262	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s); with antrostomy
31264	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s); with antrostomy and removal of antral mucosal disease
31266	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s); with frontal sinus exploration
31269	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s); with frontal sinus exploration and antrostomy
31271	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s); with frontal sinus exploration, antrostomy, and removal of antral mucosal disease
31280	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s)
31281	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s); with antrostomy
31282	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s); with antrostomy and removal of antral mucosal disease
31283	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s); with frontal sinus exploration
31284	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s); with frontal sinus exploration and antrostomy
31286	5	Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s); with frontal sinus exploration, antrostomy and removal of antral mucosal disease
31287	3	Nasal/sinus endoscopy, surgical, with sphenoidotomy
31288	3	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus

CPT code	Payment group	Body system and description
		DIGESTIVE SYSTEM
43216	1	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
43248	2	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire
43250	2	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
43261	2	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple
43458	2	Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia
44365	2	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44394	1	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45308	1	Proctosigmoidosopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
45309	1	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique
45338	1	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45339	1	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384	2	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
46611	1	Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique
49585	4	Repair umbilical hernia, age 5 or over; reducible
		LAPAROSCOPY/PERITONEOSCOPY/ HYSTEROSCOPY
56360	2	Peritoneoscopy; without biopsy
56361	3	Peritoneoscopy; with biopsy
56362	3	Peritoneoscopy; with guided transhepatic cholangiography; with biopsy
56363	3	Peritoneoscopy with guided transhepatic cholangiography; with biopsy
		EYE AND OCULAR ADNEXA
66172	4	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)

[FR Doc. 95–1897 Filed 1–25–95; 8:45 am]

BILLING CODE 4120–01–P

National Institutes of Health

Division of Research Grants; Notice of Closed Meetings

Pursuant to Section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following Division of Research Grants Special Emphasis Panel (SEP) meetings:

Purpose/Agenda: To review individual grant applications

Name of SEP: Clinical Sciences.
Date: February 22, 1995.
Time: 8:30 a.m.
Place: River Inn, Washington, DC.
Contact Person: Dr. Mushtaq Khan, Scientific Review Administrator, 5333 Westbard Ave., Room 354B, Bethesda, MD 20892, (301) 594–7168.

Name of SEP: Biological and Physiological Sciences.
Date: February 28–March 1, 1995.
Time: 8:30 a.m..
Place: St. James Hotel, Washington, DC.
Contact Person: Dr. Nancy Pearson, Scientific Review Administrator, 5333 Westbard Ave., Room 425, Bethesda, MD 20892, (301) 594–9505.

Name of SEP: Biological and Physiological Sciences.
Date: March 1, 1995.
Time: 8:30 a.m.
Place: Holiday Inn, Bethesda, MD.
Contact Person: Dr. Camilla Day, Scientific Review Administrator, 5333 Westbard Ave., Room 421C, Bethesda, MD 20892, (301) 594–7389.

Name of SEP: Biological and Physiological Sciences.
Date: March 2–3, 1995.
Time: 8:30 a.m.
Place: St. James Hotel, Washington, DC.
Contact Person: Dr. Nancy Pearson, Scientific Review Administrator, 5333 Westbard Ave., Room 425, Bethesda, MD 20892, (301) 594–9505.

Name of SEP: Behavioral and Neurosciences.
Date: March 7, 1995.
Time: 8:30 a.m.
Place: Holiday Inn, Chevy Chase, MD.
Contact Person: Dr. Lilian Pubols, Scientific Review Administrator, 5333 Westbard Ave., Room 306A, Bethesda, MD 20892, (301) 594–7325.

Name of SEP: Clinical Sciences.
Date: March 14–15, 1995.
Time: 8:30 a.m.
Place: Crowne Plaza, Rockville, MD.
Contact Person: Dr. Sooja Kim, Scientific Review Administrator, 5333 Westbard Ave., Room 348, Bethesda, MD 20892, (301) 594–7174.

Name of SEP: Clinical Sciences.
Date: March 14–15, 1995.
Time: 8:30 a.m.
Place: Crown Plaza, Rockville, MD.
Contact Person: Dr. Sooja Kim, Scientific Review Administrator, 5333 Westbard Ave., Room 348, Bethesda, MD 20892, (301) 594–7174.

The meetings will be closed in accordance with the provisions set forth in sec. 552b(c)(4) and 552b(c)(6), Title 5, U.S.C. Applications and/or proposals and the discussions could reveal confidential trade secrets or commercial property such as patentable material and personal information concerning individuals associated with the applications and/or proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

(Catalog of Federal Domestic Assistance Program Nos. 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: January 18, 1995.

Susan K. Feldman,

Committee Management Officer, NIH.

[FR Doc. 95–1896 Filed 1–25–95; 8:45 am]

BILLING CODE 4140–01–M

Division of Research Grants; Notice of Closed Meetings

Pursuant to Section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following Division of Research Grants Special Emphasis Panel (SEP) meetings:

Purpose/Agenda: To review individual grant applications.

Name of SEP: Microbiological and Immunological Sciences.
Date: February 14, 1995.